MAY, 1946

Rhode Island
MEDICAL JOURNAL

The Rhode Island Medical Society Library

NOW OPEN TUESDAY, WEDNESDAY, AND
THURSDAY EVENINGS 7-10 P. M.

THE RHODE ISLAND MEDICAL SOCIETY • HOSPITAL ASSOCIATION OF RHODE ISLAND

"for this relief... much thanks"

—Hamlet

Patients echo these words of Shakespeare when the physician provides prompt, effective control of itching. With the coming of Summer . . . exposure to sun, wind, insects, and poison ivy . . . his services in this complaint will be doubly in demand.

And they will be doubly effective, too, if ENZO-CAL is prescribed, for this pleasing, *greaseless* cream provides not only immediate relief, but long-lasting comfort. ENZO-CAL contains benzocaine which produces a mild local anesthesia of the affected areas, *plus* semi-colloidal calamine and zinc oxide which remain as a soothing, healing, protective film on the skin.

For sunburn, windburn, insect bites, poison ivy, chafing, heat rashes and other summer complaints, prescribe

Available in 2 oz. tubes and 1 lb. jars at all pharmacies.

Enzo-CAL

for ITCHING

CROOKES *Laboratories*

305 East 45th Street
New York 17, N. Y.

"Jack Spratt could eat no fat, His wife could eat no lean"....

Mrs. Spratt's B.M.R.

If Jack Spratt's wife could step out of Mother Goose and into your office —

And if you determined her **B.M.R.**—

You would probably write *"hypothyroid obesity"* on her history card.

There are many **Mrs. Spratts** in real life. To raise their lagging **B.M.R.'s** and to achieve weight reduction, physicians are now prescribing **THYROBROM** in preference to ordinary thyroid.

THYROBROM is a *brominated* thyroid preparation. *It provides every pharmacological action afforded by thryoid U.S.P., but minimizes the thyrotoxic effects of plain thyroid.*

Clinical proof of **THYROBROM'S** advantages is embodied in a recent controlled study of 60 obese persons.[1] In the same dosage as thyroid **U.S.P.**, **THYROBROM** was over

15% more effective in raising B.M.R.

35% more effective in reducing weight

64% less productive of palpitation and nervousness than thyroid U.S.P.

Each **THYROBROM** tablet contains *brominated* thyroid 2 gr., made from the finest grade of clean fat-free, desiccated whole thyroid substance. **THYROBROM'S** iodine content, 0.2% equals the **U.S.P.** standard for thyroid.

THYROBROM may be prescribed in hypothyroid obesity or in any indication for thyroid **U.S.P.** It may be tried in cases in which thyroid **U.S.P.**, is not well tolerated.

ADMINISTRATION: *Adults*—½ to 1 tablet (1 to 2 gr.) daily, preferably given in the morning. Dosage may be gradually increased to meet individual requirements, but should seldom exceed 4 gr. per day. Discontinue if untoward symptoms arise. Therapy should be controlled by periodic examinations. Any thyroid preparation is contraindicated in cardiac disease, adrenal cortex insufficiency, hypertension, diabetes and hypothyroidism secondary to pituitary dysfunctions.

HOW SUPPLIED: Bottles of 30 tablets, grooved for easy division.

LIMITED TO PRESCRIPTION USE

[1] *M. Rec.*, 158:420, 1945

Thyrobrom

typical case histories

ACUTE ULCERATIVE TONSILLITIS—

TREATMENT

6-8 Tablets Sulfathiazole Gum chewed daily.

RESULTS

Immediate improvement. Temperature normal after 72 hours.

ACUTE RHINITIS AND SECONDARY PHARYNGITIS—

TREATMENT

Sulfathiazole Gum, 1 tablet chewed for 1 hour every 2 hours.

RESULTS

Throat symptoms improved immediately, entirely disappeared after 48 hours. Patient continued with common head cold.

PLAUT-VINCENT'S ANGINA—

TREATMENT

One Sulfathiazole Gum Tablet chewed ½ to 1 hour, every hour for 8 doses.

RESULTS

Complete recovery within 56 hours.

White's SULFATHIAZOLE GUM

White's Sulfathiazole Gum now has been used with marked success in many thousands of cases of miscellaneous infections of oral and pharyngeal tissues, notably acute tonsillitis and pharyngitis, septic sore throat, infectious gingivitis and stomatitis, Vincent's infection; also indicated in the prevention of local infection secondary to oral and pharyngeal surgery.

CLINICAL ADVANTAGES:

A single tablet chewed for *one-half to one hour* provides a salivary concentration of locally active sulfathiazole averaging approximately 70 mg. per cent. Moreover, resultant blood levels of the drug, even with maximal dosage, are so low (rarely reaching 0.5 to 1 mg. per cent) that systemic toxic reactions are virtually eliminated.

Supplied in packages of 24 tablets, sanitaped in slip-sleeve prescription boxes.

IMPORTANT: Please note that your patient requires your prescription to obtain this product from the pharmacist.

A product of

WHITE LABORATORIES, INC.

Pharmaceutical Manufacturers, Newark 7, N. J.

The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: PETER PINEO CHASE, M.D.

Managing Editor: JOHN E. FARRELL

Owned and Published Monthly by

THE RHODE ISLAND MEDICAL SOCIETY

Entered as second-class matter at the post office at Providence, Rhode Island.

Single copies, 25 cents ... Subscription, $2.00 per year.

Vol. XXIX, No. 5 May, 1946

TABLE OF CONTENTS

Estrogens are excreted by the kidney not as free chemical compounds but as *conjugates.* In this natural form, the equine estrogens . . . estrone, estradiol, equilin, equilenin, and hippulin . . . are present as water-soluble sulfates which are highly active when administered orally. Under hydrolysis, however, the conjugation is destroyed and the estrogens are converted to free chemical compounds which are water insoluble and comparatively inactive orally.

In "PREMARIN", the equine estrogens are carefully protected against hydrolysis to preserve their highly desirable characteristics. "PREMARIN", therefore, is *water soluble* and orally effective, making possible the control of menopausal symptoms with tablet or liquid medication.

An extensive bibliography on "PREMARIN" attests to its high therapeutic effectiveness, its comparative freedom from toxicity, and to the fact that treatment is usually followed by a general feeling of well-being.

"Premarin"

CONJUGATED ESTROGENS (equine)

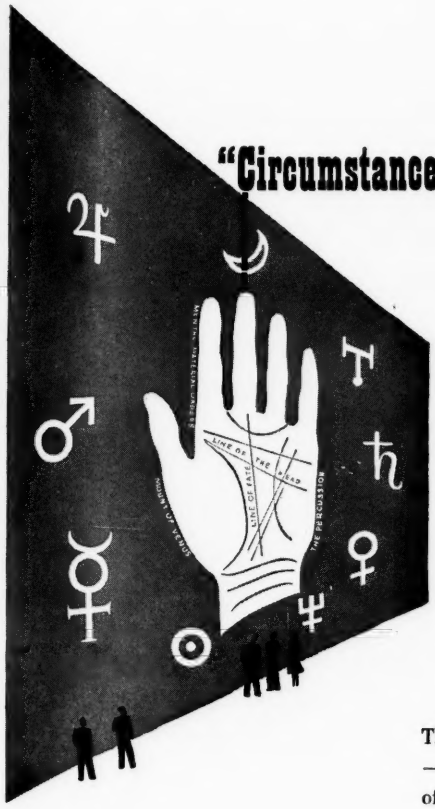
Tablet No. 866 (1.25 mg.) Tablet No. 867 (Half-Strength) (0.625 mg.)
Liquid No. 869 Each teaspoonful is equivalent in potency to one "Premarin" Half-Strength Tablet

Ayerst

AYERST, McKENNA & HARRISON Limited • 22 EAST 40TH STREET • NEW YORK 16, N.Y.

Have you read this New Practice Study?

It describes the special advantages of the Ritter Complete Treatment Room including the Ritter X-Ray for radiographic diagnosis in your own office. Hundreds of physicians have written direct to Ritter for this study. Our representative will be glad to give you a personal copy.

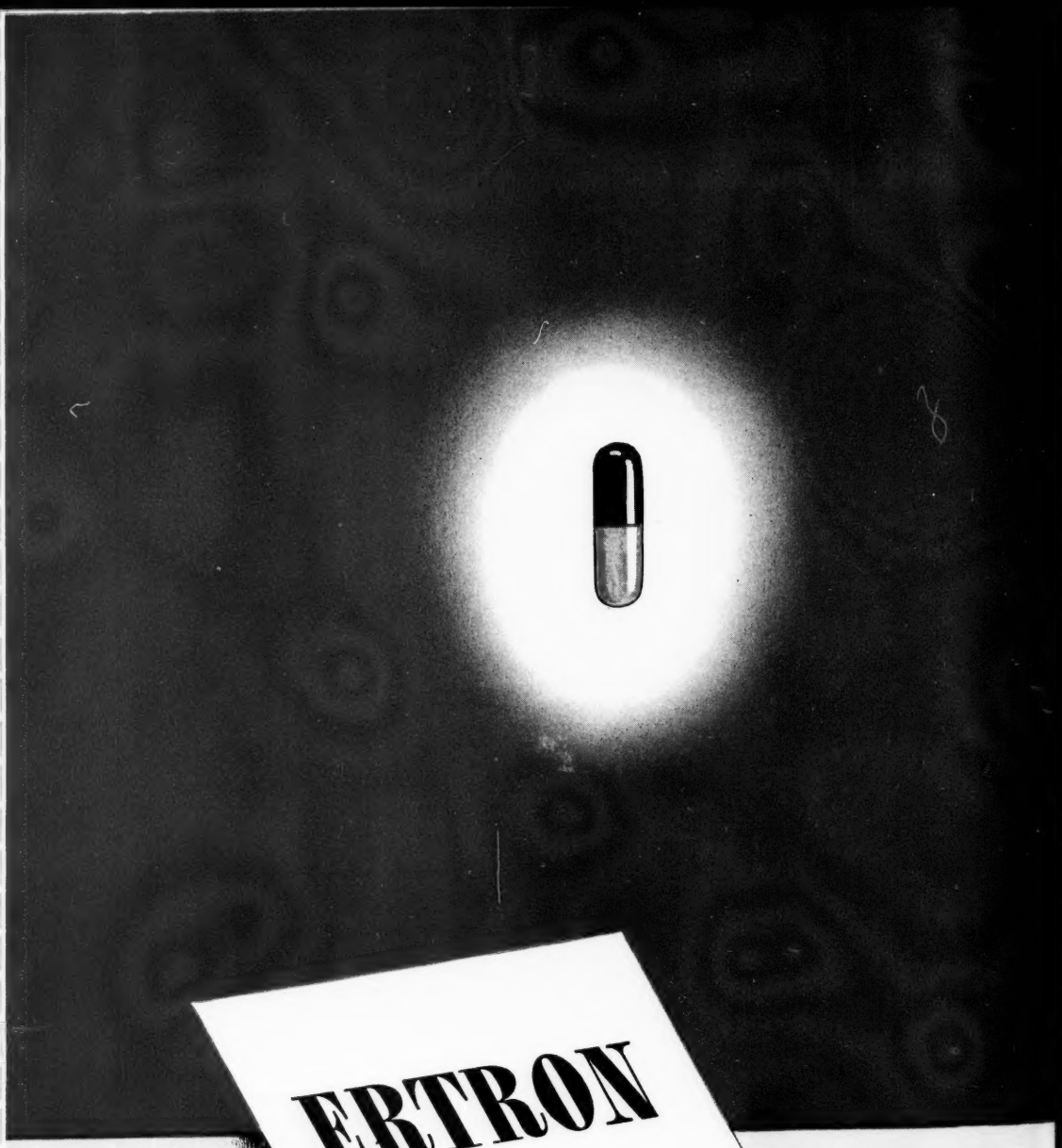


"Circumstances over which I have [X] control"

The unpredictable can of course always happen in surgery —but by rigid adherence to aseptic routine and the use of an effective antiseptic, such as Tincture Metaphen, the surgeon can control the ever-present threat of infection. In Tincture Metaphen you have a very real assurance of high antiseptic power, prolonged action and relative freedom from tissue irritation. There are other outstanding qualities you will also appreciate—its distinctive orange stain clearly delineates the operative field —it does not affect surgical instruments or rubber goods, is quite stable when exposed to air—and *now costs far less than ever before.* Tincture Metaphen 1:200 is available through hospital and prescription pharmacies in bottles containing 1 fluidounce, 4 fluidounces, 1 pint and 1 gallon. ABBOTT LABORATORIES, NORTH CHICAGO, ILLINOIS.

(Tincture of 4-nitro-anhydro-hydroxy-mercury-orthocresol, Abbott)

Tincture Metaphen



ERTRON

unlike any other antiarthritic

CLINICALLY EFFECTIVE

It is now known that Ertron is unique—differing clinically and chemically from all other drugs used as antiarthritic medication.

An extensive bibliography, based on ten years of clinical research, affords ample evidence regarding the effectiveness of Ertron in arthritis.

CHEMICALLY UNIQUE

It can now be stated, on the basis of recent laboratory research, that Ertron is chemically different.

Simply stated, Ertron is electrically activated vaporized ergosterol prepared by the Whittier Process. Each capsule contains 5 mg. of activation-products having a potency of not less than 50,000 U.S.P. Units of vitamin D.

Ertron contains a number of hitherto unrecognized factors which are members of the steroid group. The isolation and identification of these substances in pure chemical form further establish the chemical as well as the therapeutic uniqueness of Ertron.

ERTRONIZATION THERAPY

Physician control of the arthritic patient is essential for optimum effect. To Ertronize, employ Ertron in adequate daily dosage over a sufficiently long period to produce beneficial results. If signs of overdosage appear, discontinue medication for about ten days—then continue with three capsules per day gradually building up to the patient's level of tolerance.

Ertron is the registered trade-mark of Nutrition Research Laboratories

Ethically promoted

SUPPLIED IN BOTTLES OF 50, 100 AND 500 CAPSULES • PARENTERAL FOR SUPPLEMENTARY INTRAMUSCULAR INJECTION

NUTRITION RESEARCH LABORATORIES • CHICAGO

Barbiturate group

Through proper selection of the drug, dose, and route of administration, almost any degree of central nervous system depression, from light sedation to deep hypnosis, may be obtained with Lilly barbiturates. In order of increasing duration of action, Lilly barbiturates are listed as follows:

Short Acting . . . 'SECONAL SODIUM' (Sodium Propyl-methyl-carbinyl Allyl Barbiturate, Lilly)

Moderate Duration . . . 'SODIUM AMYTAL' (Sodium Iso-amyl Ethyl Barbiturate, Lilly)

Longer Acting . . . 'AMYTAL' (Iso-amyl Ethyl Barbituric Acid, Lilly)

ELI LILLY AND COMPANY, INDIANAPOLIS 6, INDIANA, U. S. A.

COLOR PHOTOGRAPH BY NAT...

Good citizen

THESE are busy times for the man of medicine. Deployment of millions of men long in the public service, adjustment of countless dislocations emanating from the war, re-establishment of normal social and economic structures, all have their effect on the health of the people. Harassed by the demands of an avid public, the physician, in the interest of good citizenship if for no other reason, labors throughout the day and much of the night, longingly hoping for the day when the return of more of his colleagues to civilian practice will give him a small measure of relief.

Neither are these easy times for the manufacturer of drugs and medicines. Shortages of raw materials, readjustment from war to peace, new allocations of personnel, all have added to the burden. Perhaps it is all for the better. New responsibilities bring new opportunities for service, the most gratifying element of all business operations. Eli Lilly and Company, with the support and co-operation of the physicians and pharmacists whom it serves, will continue to make substantial contribution to medical care with particular emphasis on both fundamental and applied research.

A picture of The Good Samaritan provided the inspiration that eventually led to the founding of Eli Lilly and Company

The RHODE ISLAND MEDICAL JOURNAL

VOL. XXIX MAY, 1946 NO. 5

THE WOOD LIGHT

As an Aid to the Diagnosis of Ringworm of the Scalp and other Dermatoses

F. RONCHESE, M.D.

The Author: *Francesco Ronchese, M.D., Dermatologist, Rhode Island and C. V. Chapin Hospital; Diplomate A.B.D.S., Instructor in Dermatology, Boston University.*

A WOOD LAMP is a diagnostic instrument which utilizes ultraviolet light passed through a nickel oxide or similar filter to remove visible light. In a dark room, under the Wood light illumination, many things invisible under ordinary conditions, become visible. It makes certain minerals or printed cloth fluoresce in a peculiar variety of shades. Focused on an old painting it makes the older colors fade almost completely and brings out distinctly the recent restorations. Lipstick marks (fig. 3) in soap-washed faces or laundered table napkins appear clearly as pale yellow spots. Figures or letters on laundered underwear or on forged checks, invisible in ordinary light appear clearly under the Wood light. Food contamination by rodents or insects, impurity in cocoa, flour, etc. are noticeable under the Wood light.

In a dark room, a beam of Wood light focused on the skin makes it appear as a ghastly mixture of increased purplish brown pigmentations over each freckle, scar or enlarged blood vessel, a palette of colors from face powders, creams, lotions, perfumes, lipsticks, etc. Any thickening and scaling of the skin appears pearl-white. The teeth, if natural, appear as fluorescent pearl-white, as does ivory, but, if artificial they are seen as violet-black or lemon-green (fig. 4). A few invisible white hairs appear vividly white.

Although invented in 1903 by the American physicist R. W. Wood, the clinical application of this light in dermatology is comparatively recent as reported by Goodman [1], Gougerot et al.[2], Lewis and Hopper[3], Costello and Luttenberger[4] and others[5].

Ringworm of the Scalp

In dermatology the Wood light is of distinct value in the diagnosis of one of the most stubborn and costly diseases of childhood, ringworm of the scalp.

In a patient of school age (ringworm of the scalp is exceptional in the infant and the adult) the experienced eye, detects ringworm of the scalp easily, from the appearance of the hairless "gray patches", stumps of broken hair, scales, or the hairless, boggy, pustular patches of kerion.

A direct examination will show the spores and micelia. The culture in the appropriate medium will determine the kind of fungus, very important for the treatment to follow.

If such a case is found in an institution where the child has lived in close contact with many other children, he has undoubtedly infected other children due to its contagiousness.

At first, only a few scattered hairs on other children may be infected, patches of alopecia, stumps of broken hair, scales, appearing only several months later. Only then will infected children be sent to a hospital, epilated with x-rays, or otherwise treated, occupying a hospital bed for many months.

When a child with a patch of alopecia, stumps of broken hair, gray scales, etc., is taken into a dark room and a beam of Wood light is focused on his scalp, if his hair are infected with one of the most common type of ringworm, the Microsporons (M. lanosum, M. audouini) that patch will not appear white, gray, yellow or violet, but vivid greenish-white (fig. 1—bottom right). Moreover, while under ordinary light only one or two round hairless spots can be seen, under the Wood light, scattered vivid greenish-white dots can be seen distinctly. These dots are single hairs loaded with spores and micelia, beginning what will later be a spot of scaly alopecia, just as contagious as the hairless areas, but invisible in ordinary light.

If the apparently healthy scalps of all other children exposed are examined in a dark room under the Wood light early infection represented by a few hairs or even a single hair may be detected, and the

continued on page 350

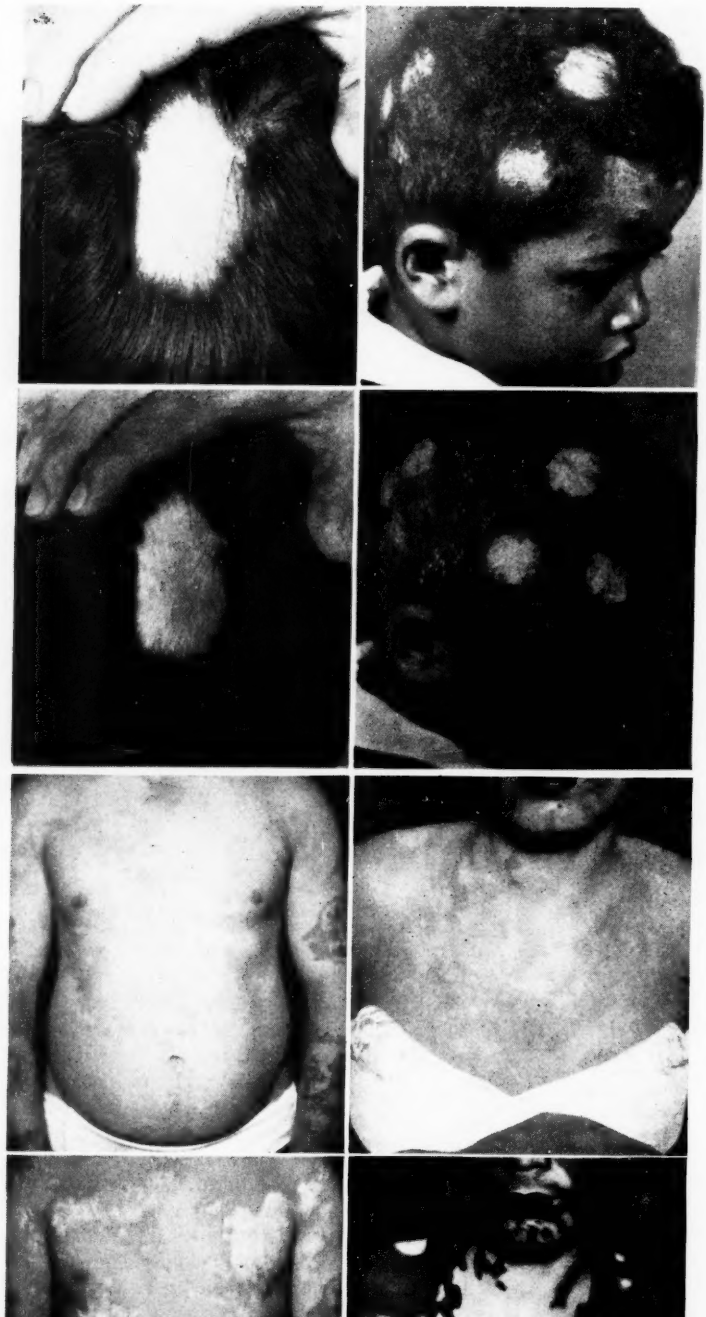


Fig. 1—The black and white ordinary photographs on the top shows a case of alopecia areata (left) and one of ringworm of the scalp (right) from Microsporon audouini, in a colored boy. The case is an advanced one and the difference between the two is clear under ordinary examining conditions. In a dark room under a beam of Wood light the same cases will appear as in the colored illustrations, the alopecia areata (left) a yellowish bald area on a violet background. Ringworm of the scalp (right) appears strikingly different. The areas of alopecia, broken hair and scales are vividly light green. This is the characteristic fluorescence of hair loaded with spores and micelia of the Microsporons, the fungi responsible for the most common type of ringworm of the scalp. The light-green dots scattered on the scalp are the beginning of a new focus of alopecia. In an apparently healthy scalp they are not visible under ordinary examining conditions, but are easily detected under the Wood light.

Fig. 2 (top)—Shows the appearance, under ordinary examining conditions, of a case of tinea versicolor (left) and one of vitiligo (right). Both show a geographic distribution, both show areas of hyperpigmentation and areas of depigmentation. Tinea versicolor in natural color would show yellowish-brown islands corresponding to the areas loaded with Malassezia furfur. In a dark room under a beam of Wood light a doubtful case will become clear. Tinea versicolor (left) will show characteristic powdered-light-golden-yellow islands on a violet background. The mildest case of vitiligo (right) will appear as a ghastly camouflaged implement of war, the depigmented areas becoming vividly white, the normal or hyper-pigmented ones deeply brown-black.

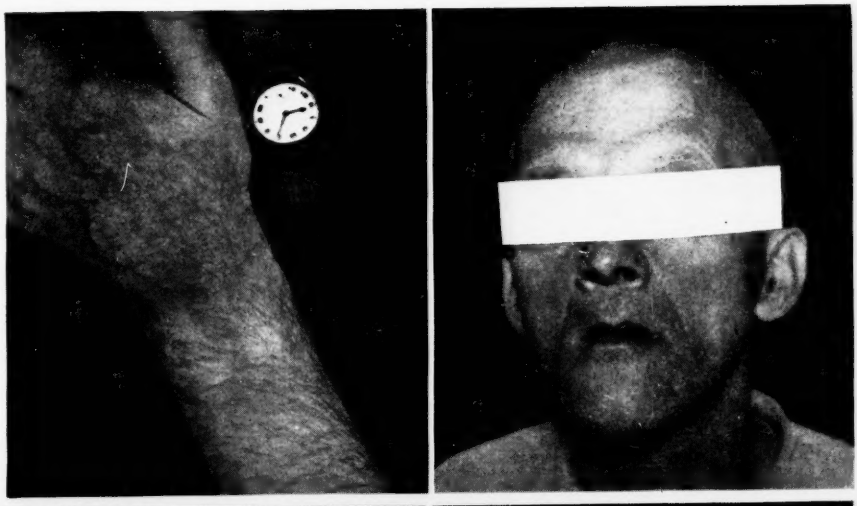
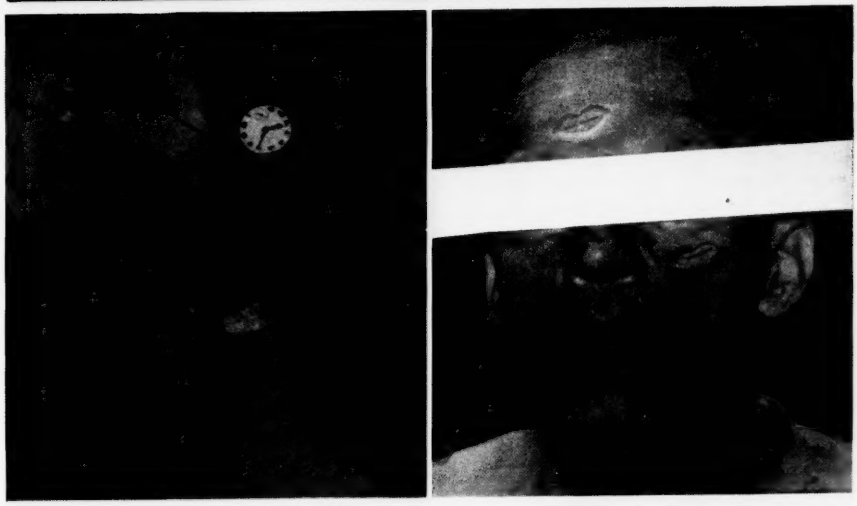


Fig. 3—Feminine osculation marks, invisible after ordinary face washing (right), appear as pale-yellow outlines under the Wood light. Wrist-watch strap dermatitis from the dye of the leather (left), invisible under ordinary circumstances, becomes visible under the Wood light. A helpful sign to prevent an eventually impending dermatitis venenata.



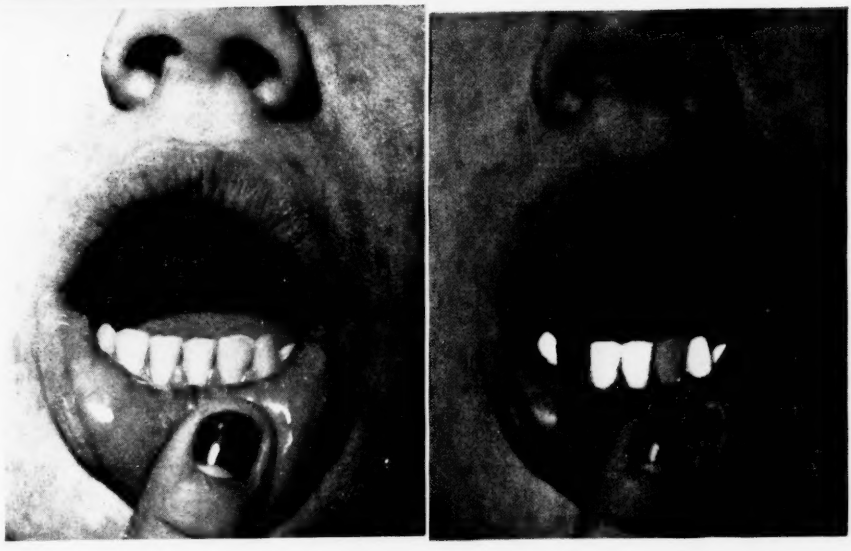


Fig. 4—The teeth at the left under ordinary light appear all alike, natural or artificial. Under the Wood light the natural ones are pearl white, the artificial, violet-black or olive green.

infected hair may be easily plucked out for examination and culture. A cure may even be obtained by the simple removal of that single hair. Without the help of the Wood light the investigator might spend hours searching for infected hairs, removing many of them (perhaps the wrong ones) and give the patient a clean bill of health, while the disease is present but unrecognized.

During and after the treatment, frequent observation will give valuable information as to success, failure, or recurrences.

Pet animals, barber shop instruments upholstered furniture in trains, theatres, etc., can be searched for fluorescent hair, which is potentially infectious.

Infectious lanugo hairs on circinate areas on children's faces or arms, although invisible under ordinary light appear greenish-white under the Wood light, as reported by Costello[6].

Tinea of the scalp *is positively present* when the hair shows the characteristic greenish-white fluorescence under the Wood light, but cannot be ruled out in its absence.

As there is no rose without a thorn nor rule without its exception, this diagnostic apparatus fails in some of the, fortunately, less common forms of ringworm of the scalp, such as tricophyton infections. Prior to direct and cultural examination, the finding of non-fluorescing hair in a clinically typical kerion suggests a resistant infection for which x-ray epilation is indicated. The fluorescing types may be successfully treated without epilation. Discussion on non-fluorescing infected hair can be found in the contributions previously quoted as well as those of Davidson, Gregory and Birt, and Cleveland[7] and of Levin and Behrman[8].

According to Lewis and Hopper[3] fungi fluoresce as follows:

All Microsporons except M. ferrugineum: yellowish-green.

Trichophyton endothrix: dull and bluish.

Achorion schoenleini: greenish (less luminous than the Microsporons).

Malassezia furfur: golden-yellow to dark brown.*

Tinea Versicolor

Tinea versicolor may be distinguished from the leukomelanodermas without extensive dermatologic experience. In general practice however tinea versicolor often is unrecognized. Areas of hyperpigmentation and depigmentation may be dismissed as incurable vitiligo or treated as such with a variety of internal and external remedies of questionable efficacy.

The young female patient with extensive tinea versicolor is ashamed to put on a bathing suit because in spite of free use of soap she appears dirty. However, even in most extensive cases there are always areas free from tinea versicolor. In contrast with these free areas, the characteristic geographic pattern, branny scales, and pinkish-brown color makes tinea versicolor easy to diagnose.

But sometimes one is in doubt, as when a youngster shows some brown round spots of geographic outline, but somewhat obscured by a coating of dirt. The Wood light becomes helpful here, removing all doubt as to what is dirt, vitiligo or tinea versicolor. The geographic patterned areas where the Malassezia furfur has made his habitat, appear as characteristic light golden-yellow powdered islands (fig. 2—bottom left).

In winter when there is less contrast, in vitiligo, between normal and depigmented areas, the whole picture is quite different. The normal or the hyperpigmented areas appear ghastly brown-black, the non-pigmented areas ghastly white, giving to the cutaneous surface the appearance of something camouflaged or of a modernistic painting. (Fig. 2—bottom right).

In such cases a warning must be given. Neurotic patients may be emotionally disturbed by the appearance of their skin, for which reason it may be advisable to cover some patient's eyes during the examination.

Other Dermatoses

In addition to ringworm of the scalp, tinea versicolor and the leukomelanodermas, early stages of macular syphilides, and the light pigmentations, remnants of unnoticed macular syphilides may be detected under the Wood light. Such are good examples of invisible dermatoses.

The one invisible nit left on a blond scalp can be easily located mostly because it appears distinctly egg-shaped.

Invisible effects of Roentgen irradiations can be studied, eventually preventing excess of dosage.

Patients denying having used any medication on their skin can be detected since many ointment bases fluoresce even after the skin has been thoroughly washed. Patches of various colors can be seen in the axillae from deodorants and antiperspiration creams, and in back of the ears and neck from perfume.

Scarred remnants of the so-called "Jericho boils" of the Armenians may sometimes pass unnoticed, but are revealed by the Wood light. The

*According to Radice (La luz de Wood en dermatologia, Revista Argentina de Dermatosifilologia, 29:101, 1945) none of his cases of tinea capitis fluoresced green. He suggests a different kind of fungi as their cause.

Cappelli (Esame della cute alla luce di Wood, Gior. Ital. di Derm e Sifil. 69:308, 1928) 18 years ago, came to the same conclusion. Perhaps all cases were due to trichophitons.

detection of invisible scars may help in personal identification[9] and hidden scars of criminal origin may be discovered.

A patient may complain of slight itching during the summer season on one wrist. Nothing is noticeable on ordinary light, but under the Wood light, a yellow band patterned from the patient's wrist-watch leather strap, (fig. 3) will indicate a stain of the skin from the dye of the leather. It may be a warning of impending dermatitis venenata which may be prevented by advising against further use of the strap.

Roffo and Roffo[10] studied the senile keratoses under the Wood light. According to these authors the more precancerous the keratoses, the more they fluoresce white because of their higher cholesterol content. If confirmed, these observations will be of importance in dermatology.

All hyperkeratotic conditions like warts, calluses, lichen verrucosus, keratosis pilaris, ichthyosis, psoriasis, false tinea amiantacea (seborrhea sicca), fluoresce vividly white, as do the nails. Molluscum contagiosum does not fluoresce except for the umbellication. Xanthoma and xanthelasma palbebrarum consisting entirely of cholesterol do not fluoresce, but appear dark-brown like freckles, or other hyperpigmented spots since there is no hyperkeratosis.

Smooth senile keratoses of the lentigo type (the ones known to the layman as liver spots) are very dark under the Wood light. I recently saw a woman, sixty years of age with a single patch of smooth senile keratosis of the type just mentioned, on her face. For the preceding two weeks the center had appeared yellowish red as if painted with mercurochrome or tincture of merthiolate. She stated that no medication whatsoever had been applied to the area. I would not have paid much attention to the discoloration if the patient had not been in a state of great nervousness because of fear of cancer. Examined under the Wood light, remnants of lipstick appeared on the lips. They were the same color as the center of the keratosis. The problem was solved and the patient's peace of mind restored.

In keratoderma punctatum, an uncommon type of keratoderma palmaris et plantaris, with a keratin defect, the punched out defective areas are darker under the Wood light. In mosaic warts, a common occurrence on the soles, with a keratin excess, the rough, keratin excessive areas are whiter than the rest of the sole.

Gougerot et al.[2] say that there is no distinction under the Wood light between lichen planus of the mouth and leukoplakia. Costello and Luttenberger[4] report that lichen planus does not fluoresce, but keratinized areas of leukoplakia fluoresce brilliantly. Gougerot and Patte[11] observed basal and squamous cell epitheliomas under the Wood light. The basal (non keratinizing) type does not show any peculiarity to distinguish it from other tumors. The squamous (keratinizing) variety shows no particular characteristics before the stage of ulceration. When ulcerated, it fluoresces as intensely red, as an incandescent lamp, or live coal. This red fluorescence is only on the surface. The deeper areas of surgically excised lesions fluoresce greenish-white.

Gougerot and Patte[11] exclude the possibility that red fluorescence is due to dental tartar (which fluoresces pink-red) because of finding it in ulcerated squamous cell carcinomas outside of the oral cavity. Hematoporphyrin-producing bacteria are suggested as a possible cause.

A Wood light is an essential part of the dermatological armamentarium. With the spread of interest in dermatology among pediatricians[12] the Wood light will doubtless become part of the pediatric armamentarium too. The public health worker and general practitioner may also find it useful.

Summary

The Wood light as a diagnostic instrument in dermatologic practice is described. Because of its power of exciting characteristic fluorescence in certain lesions indistinguishable to the human eye under ordinary illumination it is valuable in the detection of many dermatoses, particularly early cases of ringworm of the scalp and tinea versicolor.

Several Wood light apparatuses are available. According to Davis[13] a Wood light setup can be made in England at the cost of 25 shillings.

Corning Glass Works makes the glass special filter.

Hanovia has adapted it to its water cooled lamp.

Westinghouse makes a black unit using a mercury vapor Wood filter bulb. Strobilite of New York, Ultraviolet Products of Los Angelos and Black Light Products of Chicago, make Wood light projector lamps.

*Hand colored photographs by Marion Blake.

References

1 GOODMAN, H., Fluorescence: Clinical and Biological Significance in Dermatology, N. Y. State Med. J., 29:542, 1929—Fluorescence in Dermatology, Urol. & Cut. Rev. 48:119, 1944.

2 GOUGEROT, H., GIRAUDEAU and PATTE, A., De l'utilité de la lumière de Wood en dermatologie, Bull. Soc. Fr. Derm. et Syph., 45:345, 1938—GOUGEROT, H., Dermatoses invisibles, leur fréquence, leur intérêt doctrinal et pratique, Bull. Soc. Fr. Derm. et Syph., 47:361, 1940—GOUGEROT, H., and DEGOS, R. "Erythème brun" à la suite de psoriasis traités par l'éosine: lésions visibles et invisibles révélées par la lumiere de Wood, Bull. Soc. Fr. Dermat. et Syph. 46:287, 1939—GOUGEROT, H., and GIRAUDEAU, R., Sclérodermie invisible révélée par la lumiere de Wood. Ann. de Dermat. et Syph.: 1:272, 1941—GOUGEROT, H. and DUCHÊ, J., Les trois teintes, Brune, brun-violacé, rouge de l'erythrasma à la lumière de Wood, Ann. de Dermat. et Syph. 1:277, 1941—GOUGEROT, H., La lumière de Wood détectrice de l'éosinate de césium dans les épreuves d'élimination et de fixation cutanée: Rôle spécial de l'histamine, Bull. Soc. Fr. de Dermat. et Syph., 48:611, 1941.

continued on page 358

ACUTE RESPIRATORY DISEASES

A Panel Discussion given before the Providence Medical Association at its meeting at the R. I. Medical Society Library on Monday, March 4, 1946

* * * * * * * *

Introduction by ALEX M. BURGESS, M.D., *of Providence*
Chief, Medical Service, Rhode Island Hospital

WHEN Dr. Paul C. Cook, President of the Providence Medical Association, set a date for this discussion I was impressed with the great importance of the subject and I said that I think this type of discussion should be repeated quite frequently because of the new lights being shed on it year by year. As we all known more time is lost because of upper respiratory infections than any other cause. As evidence, the situation in colleges and schools. So we cannot doubt the importance of the subject. Probably ten years from now we will look back and what we say tonight will seem obsolete as what we said ten years ago would be obsolete now. Bacterial infections and the virus infections about which we know so little are with us all the time and we have to deal with them as best we can.

The plan of the discussion is this. It is absolutely unrehearsed. What we will do is this—to have each man take fifteen minutes to say his say. No one knows what the other will say and we trust that there will be some conflict of opinion and out of it all we can get a good working idea of what to do when confronted by the upper respiratory infections. I trust a number of questions will be answered. While we recognize virus infections as such what is their relationship to bacterial infections? What is the prophylactic benefit if any of a high vitamin diet, bacterial vaccines, new virus vaccines, the prophylactic use of sulfonamides? How should we treat primary atypical pneumonia, should we use penicillin? How long should we use it if it does not work? How long should we use it if it is effective? How about acute follicular tonsillitis? Should we type our pneumococci? How about aerosol penicillin? Those are the things I think you will hear answered in one way or another, perhaps in several ways.

Dr. Harold G. Calder will discuss acute respiratory infections from the point of view of the pediatrician. Dr. Francis B. Sargent will then take up the cudgel for the nose and throat service. Dr. Morgan Cutts will conclude with a presentation of the point of view of the internist.

ACUTE RESPIRATORY DISEASES FROM THE STANDPOINT OF THE PEDIATRICIAN

HAROLD G. CALDER, M.D.
Member of Consulting Staff, Rhode Island Hospital.

THERE is a larger incidence of acute respiratory disease in children than in any other age group so that we have a special interest in this subject. Before talking of the different varieties, I want to comment on sulfonamide and penicillin.

We have found sulfadiazin satisfactory and use it almost entirely. The dose in children is so much smaller in proportion to the kidney function and the resistance of the blood forming organs that it is a much safer drug than in adults. The toxic reactions are so infrequent that we are much less afraid of it than the internists are.

A recent paper (Incidence of Reactions to Sulfonamide Drugs in Infants and Children, Fiak and Smith—The Journal of Pediatrics, January, 1946) has summarized the toxic reactions in 5000 children. Whereas, in the literature generally, the average incidence in patients of all age groups is about 5 per cent, their incidence was less than 1.4 per cent. There were 60 cases of drug fever (25 per cent of them with rashes); 2 cases of neutropenia; 2 cases of hemolytic anemia; and four cases of anurea. In 300 autopsies no significant kidney damage was found. It was found that sulfonamide could be given repeatedly with various sicknesses without any tendency to sensitize to the drug. It is apparently toxic to only a few patients and they are discovered when the drug is first used.

In this series there was no routine use of alkalies. Although debate on this question is still going on, I agree that alkalies are not needed for children and are likely to do as much harm as good. Babies don't tolerate well an excess of socium ions.

This relative safety of sulfadiazine should not blind us to the fact that there is nevertheless some potential danger in its use. There is too great tendency to give it indiscriminately to every child who has a fever; there should be at least a tentative justifying diagnosis. Overdosage should be avoided. If it is going to work, the results are seen promptly, and with the clinical improvement the dose should be reduced. The medication should not be continued long if good results are not obtained.

An adequate fluid intake has always been extremely important in all febrile diseases, and it is especially so when sulfa is being taken. The rectal route is still practical and useful in the home; but parenteral administration in the hospital should be resorted to when necessary.

Although sulfadiazine is still the routine, penicillin has some advantages. It is more effective and less toxic. Because of the greater difficulties of administration and its relative scarcity, it should be reserved for the patients who have had toxic reactions to sulfa; who have not responded promptly to it; and those with the most virulent infections. If the child is sick enough to need penicillin, it should be given intra-muscularly at three-hour intervals. This has been proven reliable. The evidence for peroral use or for a one-shot-a-day is not sufficient for us to rely on them. The inhalation method should be beneficial in bronchial infections. We must guard against using this valuable drug in a careless way; it must not be wasted.

Acute respiratory infections can be caused by viruses, bacteria or both together. In general, the viruses call forth less local inflammatory reaction and less toxicity, while the bacterial infections bring greater pathological changes, more toxicity and an elevation of the white blood count. The virus diseases do not respond to chemotherapy. The diagnosis is not always easy, however, and in case of doubt a trial should be made. Bacterial involvement is so often found complicating virus disease that it may be justified to use a small dose of sulfadiazine prophylactically. There is a difference of opinion on this point, but I do not believe that this is apt to breed a variety of sulfa resistant bacteria; certainly not in a few days.

Time does not permit a full discussion of all the various respiratory diseases, and I shall emphasize only the points that are of importance in pediatrics.

Coryza in infancy is much more troublesome than in older people. The small size of the nasal passages and the baby's ignorance of any way to clear them combine to cause considerable distress. The mother can be taught to apply gentle suction with one demonstration. Nothing more elaborate than a large-sized medicine dropper is required. She should stand behind the baby and keep both her hands firmly against his cheeks so that no injury can be caused by a sudden movement. The modern nosedrops using the new vaso-constricting drugs are especially useful. The old oily drops and silver salts are not to be advised. It is very doubtful if antiseptics are of any value in the nose. The only purpose of the drops is to relieve plugging so that the nose can be cleaned. Sulfodiazine should be given if there is fever and purulent discharge.

Acute otitis-media is almost one of the childhood diseases. The important points are these—The ears should be examined at each visit. Sulfadiazine should be ordered if there is any sign of inflammation. Parenantesis is almost obsolete and is never necessary if the drug is given early enough. Its only purpose is to evacuate thick pus in a neglected case. There can be no question of the great efficiency of sulfadiazine, but it should be continued in reduced doses until the drum membrane is normal. If it is omitted too soon, a flare-up of pain and exudate may be expected. If you remember how many cases of otitis media were complicated by mastoiditis in the old days you will continue to have a healthy respect for the disease and be careful not to lose control. The mastoid operation today is evidence of too long delayed or insufficient treatment.

Another disease of childhood is croup. The common variety which appears at 9 p. m. and clears up in the morning is easily treated with steam, external heat, ipecac or iodine. When the expected improvement fails to materialize, we are dealing with one of the severe form of laryngitis. Continued evidence of obstruction should call for hospitalization and the services of a laryngologist. Diphtheria is uncommon today, but should not be forgotten. In the treatment of acute laryngo-tracheo-bronchitis sulfadiazine is disappointing, but penicillin is definitely of value. Tracheotomy is preferable to intubation when in spite of all treatment the larynx becomes obstructed.

The usual follicular tonsillitis will get well without chemotherapy, but if there is any indication of the infection spreading beyond the tonsils, as shown by redness and glandular enlargement, it should be used. One attack of tonsillitis is not an indication for tonsillectomy, in itself. Gargles, painting and spraying don't do enough good to justify their use in children's throats. Penicillin lozenges are good for the mouth, but useless for the throat.

The sudden onset of lobar pneumonia with high fever, increased respiratory rate and short cough is usually so characteristic that sulfadiazine can be

continued on next page

given before the signs of consolidation appear. The x-ray will disclose lobar pneumonia long before it can be accurately located clinically and is of particular value when the diagnosis is in doubt. This situation may happen when the presenting symptom is abdominal pain. If rapid improvement does not follow the taking of sulfadiazine, the diagnosis is probably wrong. The pneumonia may be caused by a virus and will yield to nothing but rest and time or there may be a broncho pneumonia which is much more resistant than lobar to sulfa treatment. In any event, the treatment should be changed to penicillin.

Broncho pneumonia is still a serious disease in small infants and is apt to be fatal in spite of any treatment. Penicillin and oxygen and parenteral feeding are too often unavailing in the babies who show extreme toxemia, distended abdomens and early circulatory collapse. It is quite possible the main etiological agent in these cases is a virus.

Finally, I want to comment on that ubiquitous symptom—cough. The public demands some sort of cough medicine when interfering with the cough reflex may be very bad treatment. It is certainly not good to use enough codein to depress it. The various commercial cough mixtures which have been put out are useless as far as I have observed. The cause of the cough should be treated, and enough barbiturate given to insure sleep if necessary. Hydriodic acid is still the only effective expectorant. Tracheitis usually causes the most irritating and persistent coughing and diathermy or x-ray therapy are sometimes required. Penicillin inhalations should be useful in this condition, but there is no convincing evidence as yet. This treatment makes a dramatic appeal to the public and will probably be the cause of considerable wastage of the drug.

UPPER RESPIRATORY INFECTION

FRANCIS B. SARGENT, M.D.
Surgeon-in-Chief, Department of Otorhinolaryngology, Rhode Island Hospital

THE laryngologist sees upper respiratory infection from a different angle than does the internist and pediatrician. Usually he is consulted for the later complications such as sinusitis, otitis media or laryngitis.

However, he does see patients at the onset of an upper respiratory infection when most of the infection is in the nasopharynx and treatment of this area is of primary importance if complications are to be averted. Formerly the nasopharynx was painted with iodine and glycerin and the middle turbinate region of the nose shrunken and packed with argyrol or a period of 10-15 minutes. Now tyrothricin 1:5000 is used instead of argyrol, or sulfadiazine in 2½% solution may be used. It is now well established that either tyrothricin or sulfadiazine used as a spray will prevent the complications of upper respiratory infection if used in the invasive stage.

Whether the original infection is virus or bacterial, the complications are almost always bacterial, representing secondary invasion by streptococci and staphylococci. Acute sinusitis is the most common of these complications seen in the laryngologist's office. Treatment with vasoconstrictors to promote free drainage is followed by some antiseptic such as the sulfa drugs, penicillin, tyrothricin and even argyrol. The objection to vasoconstrictors is that they diminish the blood supply of the nose in the face of infection but this is over-ruled by the necessity of establishing drainage. The antiseptic drops commonly used also have their disadvantages. Sulfathiazol is extremely irritating to the nose, not only causing paralysis of the ciliary action but also destruction of the mucous membrane. The same can be said for penicillin in strength above 250 units per c c. Furthermore, it is necessary for these agents to remain in contact with the bacteria for a period of 2½ hours, which is difficult to accomplish. 1% Ephedrine and saline is the most common form of nose drops in general use but ordinary oil nose drops with a little menthol and camphor is better tolerated by most patients.

During the Christmas holidays just past it was estimated that there were 32,000,000 cases of upper respiratory infections in the United States and Providence had its share of these. There appeared to be four distinct epidemics present at the same time. First there was the so-called influenza which was of more interest to the internist than to the laryngologist, although a few cases of sinusitis came from this epidemic.

Secondly, there was the epidemic of gastro-enteritis, intestinal grippe, which also was of little interest to the laryngologist.

Third, we had an epidemic of sore throat caused by the hemolytic streptococcus. This was characterized by very severe sore throat with a tendency

to acute otitis media. The throat showed little membrane but the anterior portion of the tongue gave a typical strawberry appearance. Without exception this disease yielded to sulfadiazine.

I saw only one patient come to operation for mastoiditis. This case had been treated with sulfadiazine which had effectively masked the symptoms. The relapse was treated in the hospital with penicillin which apparently cured the patient, giving a dry ear. However, about four weeks after the onset the patient suddenly developed typical signs of surgical mastoiditis as the infection broke through the cortex of the mastoid. At operation the mastoid was completely broken down and filled with pus which showed hemolytic streptococcus on pure culture.

The fourth infection, which is epidemic at this time, furnished most of the work for the oto-laryngologist. Undoubtedly a virus infection, it began with an intense rhinitis which lasted for three days and then almost immediately involved the sinuses. A catarrhal otitis was a frequent complication but was not as severe as the suppurative otitis started by the streptococcus epidemic. The sinusitis was very refractory to treatment and lasted from three to five weeks. There is evidence that penicillin and sulfadiazine sprays headed off the sinus complication in many of these infections if used during the first three days. Once the sinusitis was established, no such results were obtainable. Cultures taken from the middle turbinate region on these cases showed staphylococcus in 6 cases, streptococcus viridans in 6, Micrococcus catarrhalis in 12 and four were sterile. The cultures were planted on blood agar. These results were inconclusive and indicated that the organism was a virus or was of such a nature that it did not grow on ordinary culture media. It is just possible that this infection was the same one that caused the gastro-enteritis; at any rate, the gastro-enteritis and sinusitis were present in many patients at about the same time.

The sinus infections following this infection did not yield to chemotherapy by mouth. If the infection was in the maxillary sinuses, irrigation with penicillin cleared the condition, but unfortunately we were usually dealing with an ethmoiditis. Procedures designed to introduce solutions into the ethmoids are complicated and not without the danger of spreading infection to the ears.

The sulfa drugs and penicillin have revolutionized the treatment of otitis media, greatly lessening its severity and reducing mastoidectomy to 90%. No comparable results are evident in the treatment of sinusitis but with more careful bacteriological study and better selection of the sulfonamides or antibiotics to be employed, comparably favorable results in the treatment of sinusitis can be expected.

ACUTE RESPIRATORY INFECTIONS FROM THE INTERNIST'S VIEWPOINT

MORGAN CUTTS, M.D.
Assistant Physician, Visiting Staff, Department of Medicine, Rhode Island Hospital

THE whole problem of dealing with acute respiratory infections today resolves itself into distinguishing between bacterial and virus etiology. Both affect the bronchi and the lungs, and can produce serious illnesses which are roughly comparable. But upon knowing which type of agent is involved rests much of the diagnosis treatment and prognosis in any particular case.

Acute bronchitis is a good example of this. Influenza and virus pneumonia both in themselves cause inflammation of the bronchi, as do also Staph, Strep, and Pneumococci. The dry hacking cough sometimes seen in influenza may change to a purulent bronchitis after the first few days with rising WBC, Hemolytic Strep in the sputum, and a good response to diazine or penicillin—whereas at first both would have been without effect. Only making a diagnosis of bronchitis does little more than say the patient has a cough, and unless one goes further to the cause of his bronchitis, does little to help in his treatment. The WBC is probably the most useful single aid in making this decision. For symptomatic treatment, inhalations, expectorants if the cough is dry, or codein if it is too exhausting are of course helpful. If diazine is decided on it should be given in full doses with care for adequate fluid intake. 100,000 u. of penicillin/day i.m. is sufficient dosage. I believe that if specific treatment is tried without definite indication it is often disappointing, and should be discontinued after 48 hours if no improvements results.

If a diagnosis is made of a virus infection it is often difficult to distinguish between the various ones, of which there are many varieties both known

continued on next page

and unknown. It is worth attempting however in the case of two of them, influenza and virus pneumonia, because of the very different course. Typically influenza has a sudden onset, after a brief incubation period, of chill, rapidly rising fever, prostration, and general aching without localizing signs. There is a leukopenia and may be a non-productive cough. This is in contrast to the longer incubation period, and slowly increasing symptoms and fever of virus pneumonia. Also uncomplicated influenza lasts only 3-4 days, so with continuing illness it must be assumed that (1) there is infection due to secondary invaders or (2) that the whole disease was due to bacteria or to some virus other than influenza A or B.

The treatment of uncomplicated influenza is purely symptomatic. Some people ask—"why not give penicillin to all patients with flu or grippe prophylactically to prevent secondary bacterial invasion and thereby shorten the illness?" My belief is (1) most of the patients don't need it and do just as well without it, and (2) it makes for careless treatment and may confuse the diagnosis. It should certainly not be given in inadequate dosage.

An influenza vaccine is now on the market, made of equal parts of A and B. Trials have demonstrated that this vaccine affords definite but probably only brief protection—on the average the controls contracted the disease 3.2 times as often as the vaccinated. This effect persists for a few weeks or months—Reiman recommends its use only at the beginning of an epidemic whose etiology is established.

The recognition of "virus" pneumonia is less than 10 years old, yet in 1943 it was diagnosed 4 to 8 times more often in many Army hospitals than bacterial pneumonia. Once the main problem was to make a diagnosis of the type of pneumococcus, now the essential decision is whether a pneumonia is bacterial or virus. The differential points are—(1) Onset. This is gradual in virus, with no chill, pain in the chest and bloody sputum, the cough is non-productive and the fever lower at the onset. (2) P.E.—this may show little or nothing in virus pneumonia, and usually not the frank consolidation of a lobar pneumonia. (3) WBC, normal or slowly rising in the later stages or virus pneumonia (4) X-ray changes. These are more patchy and inconstant in virus pneumonia, described as fan-shaped or wedge-shaped, often extending out from the hilus into the lower lobes, and shifting from one lobe to another.

Just as chemotherapy has completely replaced serum in the treatment of bacterial pneumonia, so penicillin is in the process of replacing diazine in this disease. It is less toxic and it has a greater and wider effectiveness. The only advantage of diazine now is that it can still be given more easily at home, but even this advantage will probably vanish as oral preparations of penicillin become available that are cheaper and more regularly absorbed. Parenteral dosage of penicillin for lobar pneumonia varies between 80,000u/day and 300,000u/day—about 150,000 is probably a safe average. I believe it should be given q 3 h at first, and continued for 2 or 3 days after normal temperature in slightly lower dosage.

The use of penicillin by mouth requires 5 to 10 times the i.m. dose, and absorption is more irregular and uncertain. However, it has been used successfully in treating pneumonia, in doses of 750,000 u per day, and experimental trials are continuing.

Penicillin by inhalation is under trial now in many places. It has been used for bronchiectasis and in lung infections preoperatively, and pneumonia has been successfully treated by this means alone. 25,000 u of penicillin are dissolved in 1 or 2 cc of saline nebulized by an intermittent stream of O_2, and inhaled over a 15 minute period. This is done several times a day. It may be that this form of treatment will ultimately prove very useful in bronchitis of bacterial origin.

In practice the most vexing question is whether or not to start penicillin or diazine in an acute respiratory infection other than bacterial pneumonia. With uncomplicated influenza I believe the answer is definitely no. With virus pneumonia it is usually no, though in the latter part of the disease it is sometimes worth trying, depending on the general course, type of sputum, and WBC. But there are many other clinical pictures, not so clear-cut, starting like "grippe" or "flu", but continuing with varying fever, cough and generalized symptoms for weeks. It is in these that one is so often urged to try either the sulfonamides or penicillin. Personally I do so only rarely, when there is some increase in the WBC after the first week of illness. It is usually without effect, and if so should not be continued more than a few days. The distressing fact is that we have no specific treatment for most acute respiratory diseases—we should at least not burden the patient with useless therapy.

DISCUSSION

Dr. Burgess: It does not seem to me that we have developed any great antagonisms here, but perhaps we can get a few points that we do not agree upon. Before doing so I would like to comment a little and add one or two things that I think are quite important. First, regarding the causes of upper respiratory infections, we were taught to believe that drafts and chilling are factors in bring-

ing them on. I would like to call to your attention the report of William H. Harris, medical officer on a destroyer, who noted that in his ship's company all respiratory infections tended to disappear from two to six weeks when at sea and that no matter how much the exposure to cold or drafts and regardless of fatigue and loss of sleep, they did not start again until contact was made with other vessels or the shore. Another matter of interest—there has been reported a series of cases in which 20 per cent of the pneumococcal infections were indistinguishable from so-called primary atypical pneumonia including white blood count and x-ray appearance, and these cases responded very well to penicillin. I believe in an older person, or in one very ill, it is wrong to withhold the relatively harmless penicillin. I do not think we have mentioned how to treat the common acute follicular tonsillitis although Dr. Sargent did touch upon it.

Question: Dr. Sargent, is there any harm in letting mastoiditis quiet down by itself? You said you did not open an ear drum unless it was bulging.

Answer: No. if you feel certain that it will quiet down. In the absence of fever or pain I think that is right, but often I have seen one that developed in two or three days after being treated. Whether they would have if they had been opened I do not know. I think it is safer to open it.

Dr. Calder: I have seen that happen before we had sulfa. The ear would quiet down. I think a mastoiditis can go along more or less independently.

Dr. Burgess: Any further questions Dr. Calder?

Dr. Calder: I want to ask Dr. Cutts if a low white blood count may occur in a bacterial pneumonia.

Dr. M. Cutts: Yes, that is true, but the exception would prove the rule.

Question: You would agree that in a case of doubt you would not delay.

Dr. M. Cutts: Yes. White blood count is only a guide.

Dr. Sargent: I commented on tonsillitis. If the infection is hemolytic streptococcus you should give sulfadiazine. I did not speak of peritonsillar abscess but that is much better handled now since we have the new drug. It used to be a bad thing to have to let it ripen. Now, sulfadiazine seems to bring it to a head more quickly.

Dr. Cutts: I was interested in an article about primary atypical pneumonia and the use of one of the sulfonamides in early stage. It was given to a group and at that time reported that it was very effective in cutting down severe respiratory disease. This fall a followup article came along and described an epidemic of scarlet fever and hemolytic streptococcus infections due to two organisms which were sulfonamide resistant which had developed in that situation after a few months of treatment with sulfonamides.

Dr. Burgess: I recall that only two years ago Dr. Utter and Dr. Gregory had a few questions on this matter. Have you anything to say Dr. Gregory?

Dr. Gregory: No. I think the subject has been thoroughly discussed. I still go along with the idea of giving adequate doses of sulfadiazine or penicillin. Once I make up my mind to give it I give adequate doses. I think small doses either does the patient little good or no good at all. In other words, the patient would probably get well anyway. I cannot see how one, two or three milligrams in the blood will cure an hemolytic streptococcus infection. You have to have adequate dosage. Once I make up my mind to give sulfa I give adequate dosage. I may say in my short time in practice I have found quite a few patients with hemolytic streptococcus infections of the nasopharynx. I find they have had a course of sulfa three or four times and the patients are very pale and weak. I check the blood and urine and some had marked anemia and white blood count was low which makes the use of sulfa out of the question. I fall back on an experiment which Dr. Morgan Cutts did in the Charles V. Chapin Hospital laboratory a few years ago in which the use of small doses of sulfonamides enhanced the tolerance of H. S. so that when later on you gave adequate doses it did not stop the growth. In pneumonia I find that smaller doses do no good at all. As for peritonsillar abscess I think, very rarely have we opened a peritonsillar abscess. They come and for the first one or two days are very painful. When it localizes there is no pain at all.

Dr. Burgess: I think we are very much pleased with what Dr. Gregory says.

Dr. Calder: I agree in giving sulfa that at the beginning you should give enough. On the other hand you should reduce the dose as quickly as possible. Most of the toxic results in children are when they receive it for more than five days. The dose should be reduced as rapidly as consistent with improvement.

Dr. Kramer: I would like to ask Dr. Cutts what the difference is between the bacteria in bronchopneumonia and the later stages of virus penumonia. I could never find out because you do find various types of organisms. I have been impressed by the lack of value of penicillin in the usual brochopneumonia especially in the young and those who do not have a very high temperature.

Dr. Cutts: I do not see very much bronchopneumonia any more. I think they are usually lobar pneumonias which are bacterial or primary atypical

continued on next page

ACUTE RESPIRATORY DISEASE

continued from previous page

pneumonias. I wonder if the finding of very little response to specific treatment in bronchopneumonia means that they are really primary atypical pneumonias. You get a high percentage of pneumococci in throats. You also may find them at any time in any sputum coughed up in an atypical pneumonia. I do not think their presence means the disease is due to the pneumococci in question. Those who do not respond to penicillin are due to virus.

Dr. Burgess: My own experience has been quite the opposite. I have seen a great many bronchopneumonias particularly in older people who have responded very well and quickly to penicillin.

Dr. Utter: Tonsillitis should be treated with sulfa drug. A tonsillitis may run its course in spite of the drug. It starts in the superficial tissues of the tonsils and works into the crypt of the tonsil. At the end of five days the crypt begins to discharge. Many a time a doctor looks at a throat one day and says the child has no infection. Three or four days later he would find the tonsils swollen. If we give the sulfa drug we will prevent complications. What has become of the cervical adenitis that we used to see before the days of sulfa? You see it no longer if you give sulfa. In using sulfa we prevent the spread of infection from the Eustachian tube into the middle ear. We should give sulfa in tonsillitis always. Also in virus infections.

What is the relationship between virus infection and bacterial infection. Many have pneumococci. Virus stimulates the growth of hemolytic streptococcus in the throat. That is why the course of virus infections gives us complications. Practically always in virus infections we have other bacteria. I believe we should give sulfa in the course of virus infections. I have gone through five years of measles without complicatory infection. One other thing, the question of fear of sulfa drug and the organism becoming fast to the sulfa drug. The sulfa drugs are eliminated within thirty-six hours. How is that drug, which is entirely eliminated, going to become fast to an organism which we may meet next week or next month. We do not meet the same organism each day. I have given sulfa to children dozens of times, and I have never seen these organisms become fast.

THE WOOD LIGHT

continued from page 351

[3] LEWIS, G. M. and HOPPER, M.E., An Introduction to Medical Mycology, The Year Book Publishers, Chicago, second edition, 1943.

[4] COSTELLO, M. J. and LUTTENBERGER, L. V., Fluorescence with the Wood Filter as an Aid in Dermatologic Diagnosis, N. Y. State Med. J., 44:1778, 1944

[5] MONTESANO, V., Le dermatosi invisibili (Criptodermatosi) L'Attualitá Medica, vol. I, n°II, Rome, 193 —SUTTON, R. L. and SUTTON, R. L., Jr., Diseases of the Skin, C. V. Mosby, 10th edition reprinted with emendations, 1942—ORMSBY, O. S. and MONTGOMERY, H., Diseases of the Skin, Lea and Febiger, 1943—CONANT, N. F., et al., Manual of Clinical Mycology, Saunders, 1944—LEWIS, G. M., SILVERS, S. H., CIPOLLARO, A. C., MUSKABLIT, E. and MITCHELL, H. H., Measures to Prevent and Control an Epidemic of Ringworm of the Scalp, N. Y. State Med. J., 44:1327, 1944—DeMENT, J., Fluorochemistry, Chemical Publishing Co., Brooklyn, N. Y., 1945.

[6] COSTELLO, M. J., Tinea Corporis with Fluorescent Lanugo Hairs, Arch. Derm. 49:385, 1944.

[7] DAVIDSON, A. M., GREGORY, P. H. and BIRT, A. R., A Clinical and Mycological Study of Suppurative Ringworm, Canad. M. A. J. 31:587, 1934—CLEVELAND, D. E. H., Infectivity of Fluorescent Hairs in Scalp Ringworm, Canad. M. A. J., 49:280, 1943.

[8] LEVIN, O. L. and BEHRMAN, H. T., The Problem of Nonfluorescent Ringworm of the Scalp, J. A. M. A. 128:350, 1945.

[9] RONCHESE, F., Calluses, Cicatrices and other Stigmas as an Aid to Personal Identification, J. A. M. A. 128:925, 1945.

[10] ROFFO, A. H. and ROFFO, A. E., Jr., La fluorescencia de las lesiones hipercolesterínicas precancerosas, excitada con la luz de Wood, Boletin del Instituto de Medicina Experimental, n°51, p. 209, 1939—La fluorescencia de las lesiones hipercolesterínicas de la piel en el diagnóstico precoz del cáncer. Metodo de fotografía directa, Boletin del Instituto de Medicina Experimental, n°56, p. 69, 1941—Also: De CASTRO, M. and De ALMEIDA, O., A fluorescencia da pele normal, das lesões cutaneas e dos faneros. Sua relação com a presença de queratina e lipides, Resenha Clinico-Cientifica (S. Paulo-Brazil), 11:119, 1942.

[11] GOUGEROT, H. and PATTE, A., Fluorescence des épithéliomas à la lumière de Wood, Bull. de la Soc. Fr. Derm. et Syph., 46:288, 1939.

[12] PERLMAN, H. H., A Clinical Appraisal of the Treatment of the Dermatomycoses of Children, Urol. & Cut. Rev. 49:97, 1945.

[13] DAVIES, J. H. T., A Wood's Glass Diagnosis Lamp for Twenty-Five Shillings, Br. J. Derm., 45:193, 1933.

The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society,
106 Francis Street, Providence, Rhode Island

THE HEALTH ACT

On April 3 the proposed health act drafted by a special public health survey laws commission of fifteen members was printed and distributed by the General Assembly. The printing of the act provided the first opportunity for the Rhode Island Medical Society, the largest professional group affected by the proposed legislation, to know of the proposals of the commission. On April 4 the joint committee on health of the General Assembly called a hearing on the bill. The Society reported that it could not comment until its Committee on Public Laws had viewed the legislation, and it promised to submit recommendations in writing within the following week. On April 10 the Society, through the Committee on Public Laws, made known in writing to the Assembly committee its recommendations for amending the bill. That committee accepted but three minor amendments, and then reported the bill out with approval. The House passed the act. The Senate objected that it had been introduced too late in the session, that sufficient time was not allowed for careful study of it, and therefore it should be held until the next session of the Assembly. The latter action prevailed. Subsequently the chairman of the Joint Committee on Public Health secured passage of resolution to continue the special survey laws commission until next February. Such, in brief, is the legislative history of the health act.

The action of the Society in no manner criticized the work of the commission that undoubtedly gave generously of its time to improve the present health laws. For that matter when the resolution that created the commission was before the Assembly in 1943 the Society pointed out to that body that the amount of work planned could not be completed in the allotted time, and it recommended that the proposal be amended to include legal representatives to assist in the task.

Although the Commission had been in service since 1943, it had never requested the Rhode Island Medical Society to come before it at any time to make known any of its views, or to assist in forming any decisions that would mainly affect the medical profession of this state. Therefore, the Society had no alternative other than a presentation of amendments when the legislation was finally before the Assembly and available for public reading.

Three amendments of the approximately twenty-one amendments submitted by the Society were approved by the Public Health Committee of the Assembly. Strange to relate, the major amendment accepted, that relative to the right to require full citizenship as a prerequisite for licensure, was accepted only in part, thereby making the amendment as accepted inconsistent with a parallel provision further in the act..

continued on next page

The major objections of the Society, as clearly set forth in published statements pointing to faults existing in the present or proposed laws, included the following: failure to clarify the term "physician" which in some instances applies only to a doctor of medicine and in others to an osteopathic or a chiropractic physician also; failure to improve the cancer control program as long advocated by the Society, whereby a cancer commission would initiate a long-range program in cooperation with the state health department; failure to amend properly the clarification relative to citizenship requirements; failure to make provision for the exemption of state licensure for physicians in the newly created Veterans Administration Corps, as is provided for the Army, the Navy, and the USPHS; failure to clarify just what constitutes the practice of osteopathy in this state; failure to clarify the very ambiguous term "major surgery" used in the law without definition of what it constitutes; and failure to present evidence to justify the extension of privileges to chiropractic physicians beyond the scope of their recognized training.

The Society by no means merely presented objections to these faults. It honestly and conscientiously attempted to correct them by submitting amendments that did not deprive anyone now licensed under the healing art of privileges within the scope of his recognized training and licensure.

The health act now goes back to the study commission. It is to be hoped that public hearings for the purpose of discussing the views of the Rhode Island Medical Society, as well as those of other interested groups, may be held in ample time to permit the improvement of the act for presentation early in the January session of 1947.

DR. OLIN WEST

On April 1 Dr. Olin West retired as secretary-general manager of the American Medical Association. For well on towards a quarter century his name has been familiar to all its members. They knew that over this long period he had done a good part in running this great and beneficent organization. A smaller, but still large number of physicians, members of the House of Delegates, state secretaries and editors of state journals, had in their frequent trips to Chicago made intimate contact with him and become well acquainted.

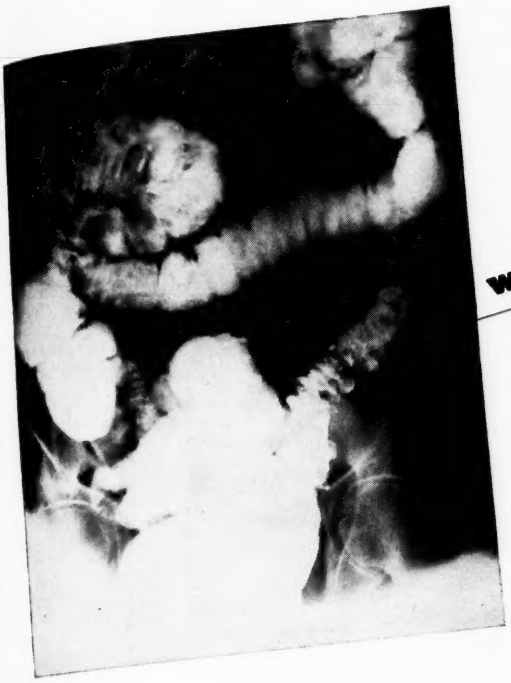
This group particularly are going to miss his presence at their meetings. He was the guiding spirit. He knew all the answers. He was always right there seeing that things were moving in the proper direction and smoothly. There was no doubt that he was a capable, efficient secretary-manager. But what lingers longest and most fondly is his personality. His deep, well-modulated voice has just enough southern accent to let you know where he came from. This, joined with his long gaunt form, slender face and graying hair, suggests Henry Clay or possibly Davy Crockett, but not John C. Calhoun or Andrew Jackson. There is nothing of the fire-eating Southerner about him. His kindly ways and friendly manners are as far from this as possible. If one hobnobs with him in a small group and hears his charmingly told stories of life below the Mason-Dixon line, one is reminded then of Joel Chandler Harris of Uncle Remus fame.

His career, almost entirely devoted to organized medicine, is sketched in a recent number of J. A. M. A. and a well deserved tribute is paid there to the value of his work. May he still continue to lend his counsel and advice, but avoid responsibility and enjoy a dolce far nienti, away we trust, at times, from the rigorous lake breezes of Chicago and in the soft Southern clime of his boyhood.

A WOMAN'S AUXILIARY

The proposal that the Society have a woman's auxiliary is certainly a commendable one. The value of such an organization has been well demonstrated in forty-two states, and it is surprising to know that we in Rhode Island have been one of the last to recognize the fact that our wives form one of organized medicine's greatest assets. Not alone because they have suffered with us all these years, watching us disappear day and night on sick calls or to medical meetings and conferences, but more because they, of all groups, best understand and appreciate the scope of the physician's work, do our wives deserve this recognition as an affiliate of our historic medical society.

When the war forced the elimination of our annual Society dinner the social hour substituted, to which wives of members were invited, proved one of the highlights of the annual meeting. There is little doubt, then, that as a social organization the Auxiliary would be successful; as a formidable group to carry to every corner of our State the story of organized medicine, its ideals, its purposes, and its plans for the benefit of all the people, its possibilities are limitless.



when spasm means pain . . .

PAVATRINE with PHENOBARBITAL affords potent, swift, non-narcotic relief through relaxation of gastrointestinal smooth muscle.

The effectiveness of PAVATRINE as an antispasmodic has now been enhanced by the addition of phenobarbital to allay the central nervous symptoms that so often accompany spastic phenomena.

PAVATRINE with Phenobarbital

PAVATRINE (Searle) . . . . . 125 mg. (2 gr.)
(β-diethylaminoethyl fluorene-9-carboxylate hydrochloride)
PHENOBARBITAL . . . . . 15 mg. (¼ gr.)

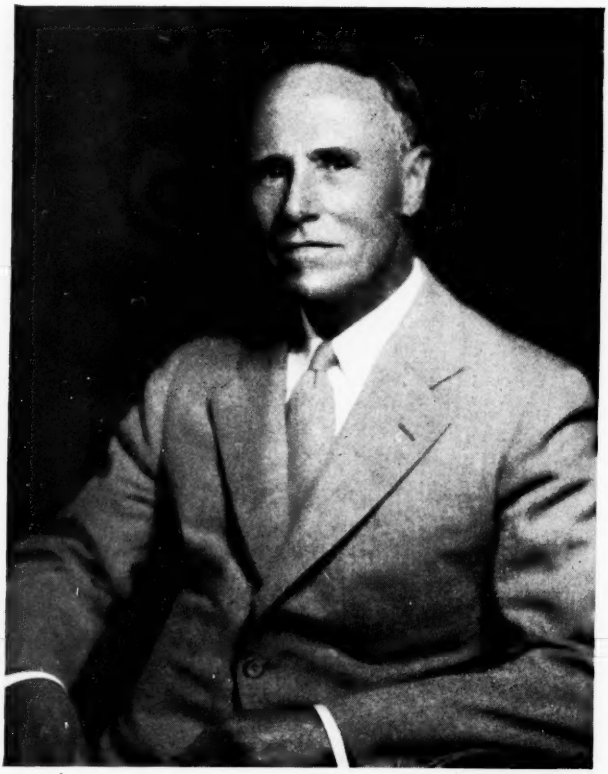
—the new, synthetic antispasmodic which exerts both a local action on smooth muscle and a neurotropic effect on the nerve supply to the spastic muscle. Free from the toxic manifestations of the belladonna derivatives, PAVATRINE, in combination with phenobarbital, provides complete management for the distress of gastrointestinal, uterine and genito-urinary spasm.

Indicated for relief of:
Gastrointestinal spasm
Uterine spasm associated with dysmenorrhea
Urinary bladder spasm (as in cystitis, post-instrumentation spasm, etc.)

Pavatrine is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE



HERMAN C. PITTS, M.D.

of Providence, R. I.

President of the RHODE ISLAND MEDICAL SOCIETY

1946-47

To the Officers and Fellows of the Rhode Island Medical Society

THERE is nothing static in all this universe of ours. Even the "eternal hills" are not eternal, for every year their heighth and bulk are reduced by the erosion of wind and water.

Alas, Medical Societies are not exempt from this general law. They must go forward or else slip back to a plane of lesser usefulness and lesser influence!

As your leader for the coming year, I can see several problems ahead that will need the hearty efforts of every one for their satisfactory solution.

First of all the acceptance by the Members of the Society of the proposed Voluntary Surgical Benefits Plan. Your House of Delegates has pledged itself to the establishment of such a plan. The one proposed may not be ideal—no plan can suit every one. But let us all get behind the one finally adopted, give it a thorough trial and then when weak spots are found, strengthen them. I believe that whatever we can do to develop any type of voluntary health insurance erects a barrier against the adoption of a national compulsory health insurance law that will certainly put us in the same unfortunate position the English physicians find themselves.

Then we have the returned veteran. We owe him a great debt for the sacrifices he has made in defense of our country. Whatever we can give him of our time and skill is a very small payment against that debt. That we should be helpful and generous at all times to our professional associates returned from the armed forces goes without saying.

I should like to emphasize what my far-sighted predecessor has already said, Viz., that we as Members of the State Medical Society should take a greater interest in the making and enforcing of laws dealing with the health problems of the whole state. The pollution of our bay waters for instance is a disgrace. It affects not only the pleasure of our people but also their health. We can exert some influence surely by talking and writing in obtaining better conditions.

Lastly I should like to emphasize again that public relations begin, and I might say end, with the conduct of each member of our profession. The public judges standing and worth by the skill, patience, tact and honesty each one of us exercises toward each patient.

I ask for the help and co-operation of you all. With it, we can advance to a position of greater influence and of greater usefulness to the community.

HERMAN C. PITTS, M.D., *President*

what price straight legs?

Although no price is too great to pay for strong bones and straight legs, actually antirachitic protection can be provided at a very economical figure.

ONLY ONE CAPSULE PER MONTH OF Infron *Pediatric*

ETHICALLY PROMOTED

provides adequate prophylaxis against, or treatment of, rickets and other calcium deficiencies. The efficacy of this unusual therapy is well established by the clinical work of Wolf, Rambar, Hardy and Fishbein.

Each capsule of Infron Pediatric contains 100,000 U.S.P. Units of vitamin D—Whittier Process—especially prepared for pediatric use. Readily miscible in the infant's feeding formula, milk, fruit juices, or water, and can also be spread on cereal.

Supplied in packages of 6 capsules—sufficient dosage for 6 months. Available at prescription pharmacies.

REFERENCES:

Rambar, A. C., Hardy, L. M., Fishbein, W. I.: J. Ped. 23:31-38 (July) 1943

Wolf, I. J.: J. Ped., 22:707-718 (June) 1943

Wolf, I. J.: J. Ped., 22:396-417 (April) 1943

Wolf, I. J.: J. Med. Soc. New Jersey, 38:436 (Sept.) 1941

NUTRITION RESEARCH LABORATORIES • CHICAGO

Please send literature and a supply sufficient for 6 months' clinical trial.

R.I.M J-5

DR. _____

ADDRESS _____

CITY _____ STATE _____

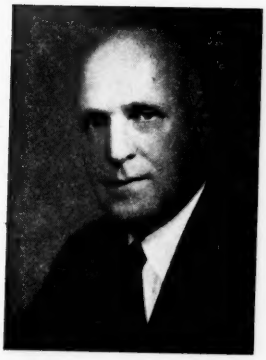
RHODE ISLAND MEDICAL SOCIETY

Officers 1946-47

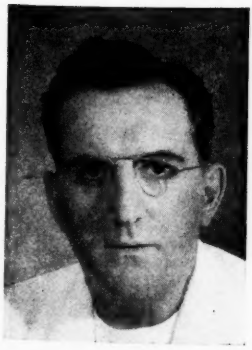
MICHAEL H. SCANLON, M.D.
Vice-President

MORGAN CUTTS, M.D.
Secretary

CHARLES J. ASHWORTH, M.D.
Treasurer



ARTHUR H. RUGGLES, M.D.
President-Elect



CHARLES B. CEPPI, M.D.
Assistant Secretary

G. RAYMOND FOX, M.D.
Assistant Treasurer

A NEW CEREAL FOR

Infants and Children WITH PAPAYA FRUIT

DRIED FRESH TO PRESERVE NATURAL ENZYMES AND PECTINS

THE LATEST ADDITION to the famous S. M. A. Infant Foods —CEROL . . . something new in infant feeding—FLAVORED . . . with mellow papaya fruit—FORTIFIED . . . with vitamins and minerals — READY TO SERVE . . . a nutritious, precooked, multigrain cereal—Supplied in 8 oz. packages.

Wyeth

REG. U. S. PAT. OFF.

S. M. A. DIVISION • WYETH INCORPORATED • PHILADELPHIA 3 • PA.

HOSPITAL ASSOCIATION OF RHODE ISLAND

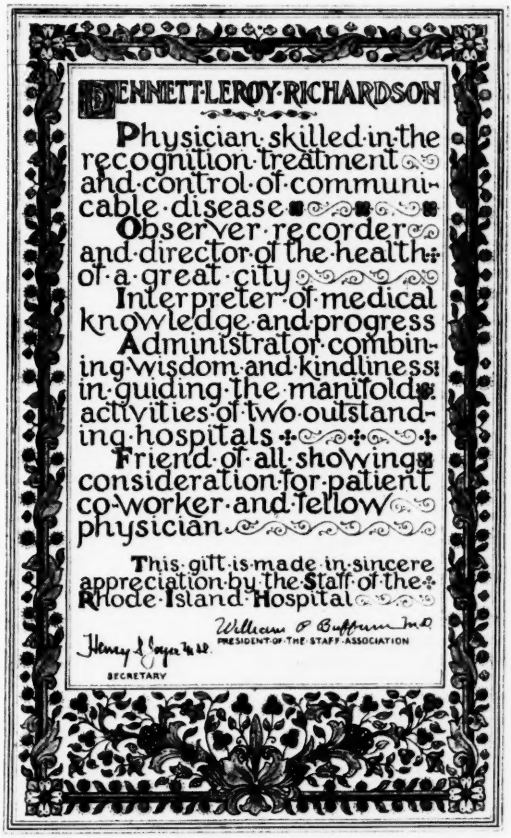
THE STATE HOSPITAL FOR MENTAL DISEASES

HOWARD, RHODE ISLAND

SEVEN miles southwest of Providence on Reservoir Avenue is situated the Rhode Island Hospital for Mental Diseases with its modern equipment and competent staff of Doctors, Nurses, and associate personnel. This institution represents the untiring and ceaseless efforts of the progressive forces in the State in seeking humane care for their less fortunate comrades. The history and development of this hospital to its present status should therefore be of interest to us.

During the sessions of the Rhode Island Assembly from 1867 to 1869, various resolutions were adopted leading to the purchase of the Wm. A. Howard Farm in Cranston and the creation of the State Board of Charities and Corrections. This land was to be used for the construction of the House of Correction and the State Asylum for the Insane, and for what other purposes the General Assembly might direct. The first meeting of the Board was held July 30, 1869. The Chairman was authorized to procure specifications and estimates for the construction of one-story buildings to house the incurable pauper insane. These buildings were to be patterned after those at the lunatic asylum, Blackwells Island, New York. Construction was finally completed and the first patients admitted on November 7, 1870. Until March 1, 1885 the state law limited admissions to state and town charges who were incurably insane. On the above date, the General Assembly passed laws which made it possible for the commitment of recent cases of insanity to the asylum without prior treatment at a hospital which cared for acute cases. The State, in consequence, accepted the responsibility for all types of mental disease. The administrative control of the hospital can be divided into two periods, the period of the State Farm and Deputy Superintendencies which lasted from November 7, 1870 to May 21, 1897 and the period of Medical Superintendencies commencing May 21, 1897 and extending to present day. During the first period, the Superintendent of the State Farm was charged with the administration of four (4) departments, the House of Correction, the State Work House, the State Almshouse and the Asylum for the

continued on next page



Facsimile of the citation to Dr. Dennett L. Richardson by the staff of Rhode Island Hospital on the occasion of his retirement as Superintendent.

The major objections of the Society, as clearly set forth in published statements pointing to faults existing in the present or proposed laws, included the following: failure to clarify the term "physician" which in some instances applies only to a doctor of medicine and in others to an osteopathic or a chiropractic physician also; failure to improve the cancer control program as long advocated by the Society, whereby a cancer commission would initiate a long-range program in cooperation with the state health department; failure to amend properly the clarification relative to citizenship requirements; failure to make provision for the exemption of state licensure for physicians in the newly created Veterans Administration Corps, as is provided for the Army, the Navy, and the USPHS; failure to clarify just what constitutes the practice of osteopathy in this state; failure to clarify the very ambiguous term "major surgery" used in the law without definition of what it constitutes; and failure to present evidence to justify the extension of privileges to chiropractic physicians beyond the scope of their recognized training.

The Society by no means merely presented objections to these faults. It honestly and conscientiously attempted to correct them by submitting amendments that did not deprive anyone now licensed under the healing art of privileges within the scope of his recognized training and licensure.

The health act now goes back to the study commission. It is to be hoped that public hearings for the purpose of discussing the views of the Rhode Island Medical Society, as well as those of other interested groups, may be held in ample time to permit the improvement of the act for presentation early in the January session of 1947.

DR. OLIN WEST

On April 1 Dr. Olin West retired as secretary-general manager of the American Medical Association. For well on towards a quarter century his name has been familiar to all its members. They knew that over this long period he had done a good part in running this great and beneficent organization. A smaller, but still large number of physicians, members of the House of Delegates, state secretaries and editors of state journals, had in their frequent trips to Chicago made intimate contact with him and become well acquainted.

This group particularly are going to miss his presence at their meetings. He was the guiding spirit. He knew all the answers. He was always right there seeing that things were moving in the proper direction and smoothly. There was no doubt that he was a capable, efficient secretary-manager. But what lingers longest and most fondly is his personality. His deep, well-modulated voice has just enough southern accent to let you know where he came from. This, joined with his long gaunt form, slender face and graying hair, suggests Henry Clay or possibly Davy Crockett, but not John C. Calhoun or Andrew Jackson. There is nothing of the fire-eating Southerner about him. His kindly ways and friendly manners are as far from this as possible. If one hobnobs with him in a small group and hears his charmingly told stories of life below the Mason-Dixon line, one is reminded then of Joel Chandler Harris of Uncle Remus fame.

His career, almost entirely devoted to organized medicine, is sketched in a recent number of J. A. M. A. and a well deserved tribute is paid there to the value of his work. May he still continue to lend his counsel and advice, but avoid responsibility and enjoy a dolce far nienti, away we trust, at times, from the rigorous lake breezes of Chicago and in the soft Southern clime of his boyhood.

A WOMAN'S AUXILIARY

The proposal that the Society have a woman's auxiliary is certainly a commendable one. The value of such an organization has been well demonstrated in forty-two states, and it is surprising to know that we in Rhode Island have been one of the last to recognize the fact that our wives form one of organized medicine's greatest assets. Not alone because they have suffered with us all these years, watching us disappear day and night on sick calls or to medical meetings and conferences, but more because they, of all groups, best understand and appreciate the scope of the physician's work, do our wives deserve this recognition as an affiliate of our historic medical society.

When the war forced the elimination of our annual Society dinner the social hour substituted, to which wives of members were invited, proved one of the highlights of the annual meeting. There is little doubt, then, that as a social organization the Auxiliary would be successful; as a formidable group to carry to every corner of our State the story of organized medicine, its ideals, its purposes, and its plans for the benefit of all the people, its possibilities are limitless.

HOSPITAL ASSOCIATION OF RHODE ISLAND

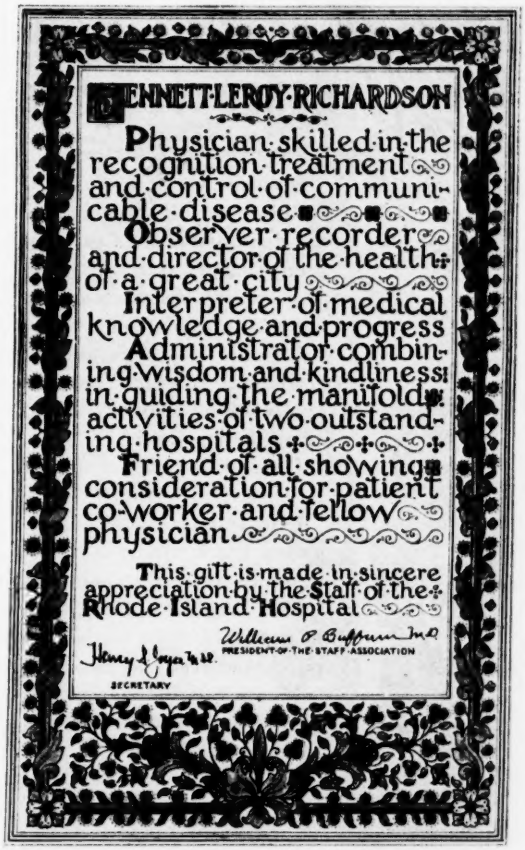
THE STATE HOSPITAL FOR MENTAL DISEASES

HOWARD, RHODE ISLAND

SEVEN miles southwest of Providence on Reservoir Avenue is situated the Rhode Island Hospital for Mental Diseases with its modern equipment and competent staff of Doctors, Nurses, and associate personnel. This institution represents the untiring and ceaseless efforts of the progressive forces in the State in seeking humane care for their less fortunate comrades. The history and development of this hospital to its present status should therefore be of interest to us.

During the sessions of the Rhode Island Assembly from 1867 to 1869, various resolutions were adopted leading to the purchase of the Wm. A. Howard Farm in Cranston and the creation of the State Board of Charities and Corrections. This land was to be used for the construction of the House of Correction and the State Asylum for the Insane, and for what other purposes the General Assembly might direct. The first meeting of the Board was held July 30, 1869. The Chairman was authorized to procure specifications and estimates for the construction of one-story buildings to house the incurable pauper insane. These buildings were to be patterned after those at the lunatic asylum, Blackwells Island, New York. Construction was finally completed and the first patients admitted on November 7, 1870. Until March 1, 1885 the state law limited admissions to state and town charges who were incurably insane. On the above date, the General Assembly passed laws which made it possible for the commitment of recent cases of insanity to the asylum without prior treatment at a hospital which cared for acute cases. The State, in consequence, accepted the responsibility for all types of mental disease. The administrative control of the hospital can be divided into two periods, the period of the State Farm and Deputy Superintendencies which lasted from November 7, 1870 to May 21, 1897 and the period of Medical Superintendencies commencing May 21, 1897 and extending to present day. During the first period, the Superintendent of the State Farm was charged with the administration of four (4) departments, the House of Correction, the State Work House, the State Almshouse and the Asylum for the

continued on next page


DENNETT·LEROY·RICHARDSON
Physician skilled in the recognition treatment and control of communicable disease
Observer recorder and director of the health of a great city
Interpreter of medical knowledge and progress
Administrator combining wisdom and kindliness in guiding the manifold activities of two outstanding hospitals
Friend of all showing consideration for patient co-worker and fellow physician
This gift is made in sincere appreciation by the Staff of the Rhode Island Hospital
William O Buffum M.D. PRESIDENT OF THE STAFF ASSOCIATION
SECRETARY

Facsimile of the citation to Dr. Dennett L. Richardson by the staff of Rhode Island Hospital on the occasion of his retirement as Superintendent.

STATE HOSPITAL FOR MENTAL DISEASES

continued from previous page

Chronic Insane. The Superintendent of the State Farm was responsible to the State Board of Charities and Correction for his administration and each of the four departmental heads or Deputy Superintendents were responsible to him.

An act was passed by the General Assembly in 1897 separating the hospital from the State Farm and changing its name to the State Hospital for the Insane. The Board of Charities and Correction was authorized to appoint a Superintendent for the hospital who should be a physician. The first Medical Superintendent took office May 21, 1897. From 1897 to 1912 further expansion of the physical plant took place which more adequately met the needs of the patients. There was also constant agitation for an enlarged medical staff, for better medical and surgical facilities, and the creation of a Nursing Staff and School.

On May 28, 1912, a Reception Hospital was completed and occupied. Soon after its occupancy, there was established a modern department of Pathology and Laboratories, a Nursing Staff and School, Department of Occupational Therapy, and a Surgical and X-Ray unit. In 1915 the first class of Nurses was graduated. In 1916 a Social Service Worker was added to the Staff. This service has since expanded into a department with five full time workers and sponsors a training course for students. By 1932 the Mental Hygiene Program sponsored by the hospital was expanded and Community Mental Hygiene Clinics were established in outlying districts in the State. These were under the hospital's jurisdiction and staffed by personnel from the hospital. A new building program was initiated in 1934 and completed in 1938. The hospital was then divided into the following services and remains the same to this day. These services are: The Individual Treatment Service, the Medical and Surgical Service, Senile Service, Male and Female Continuous Treatment Service, Tuberculosis Sanitarium, Criminal Insane, and Department of Pathology and Laboratories. There has also existed in the hospital for many years, a consultant staff made up of outstanding specialists in the State in the various specialties. The people in the State of Rhode Island owe these men a debt of sincere gratitude for their untiring efforts and interest on behalf of the patients for which they receive no compensation. Until the onset of World War II, there was an active educational program for doctors, nurses, and the personnel of the various departments in their respective fields. During the War certain departments found it necessary to operate with skeleton crews because of help shortages resulting in some regression of service. Most gains have been maintained,

continued on page 390

HOSPITAL LEGISLATION ENACTED BY GENERAL ASSEMBLY

SENATE ACT 245

(Passed in concurrence by the R. I. General Assembly on April 17, 1946)

TO INCORPORATE
KENT COUNTY MEMORIAL HOSPITAL

SECTION 1. Whitman Merrill, M.D., President of Kent County Medical Society, Peter Erinakes, M.D., Vice-President of Kent County Medical Society, Jeannette E. Vidal, M.D., Secretary of Kent County Medical Society, and John A. Mack, M.D., Treasurer of Kent County Medical Society, and their associates, who may be admitted to membership of the corporation hereinafter created according to the by-laws thereof, are hereby made a corporation by the name of Kent County Memorial Hospital for the purpose of organizing, erecting, acquiring, equipping, supporting, operating and maintaining a non-profit hospital for the sick, disabled and injured in Kent County, in the State of Rhode Island; and in connection therewith and for the purpose of carrying into full effect the charitable and humane intentions of the corporation, to acquire land by purchase, lease, gift or devise, and to erect thereon or otherwise acquire suitable buildings and equipment, with all powers and privileges and subject to all other duties and liabilities set forth in chapter 259 of the general laws of 1938, and in any acts in amendment thereof or in addition thereto.

SEC. 2. The said corporation may take and receive, hold, purchase and possess real and personal estate to be used and employed for the erection, support, operation and maintenance of a hospital in Kent County in the State of Rhode Island, and for carrying into full effect the charitable and humane intentions of the corporation to any amount necessary or proper, but not to exceed $5,000,000.00: and may sell and dispose of the same; and the property and estate of said corporation, both real and personal, shall not at any time be liable to be assessed in the apportionment of any state, city or town tax.

SEC. 3. In addition to all other purposes said corporation is hereby authorized, and empowered to carry on the work of educating and training nurses, and, for that purpose, to institute and maintain a training school for nurses and to grant certificates for work performed at such school and diplomas to graduates thereof.

SEC. 4. This act shall take effect from and after its passage.

Final Action

HOUSE RESOLUTION — 1028

(Passed by the House of Representatives, R. I. General Assembly, 1946)

REQUESTING HIS EXCELLENCY, GOVERNOR JOHN O. PASTORE, TO APPOINT A SPECIAL COMMITTEE TO MAKE A SURVEY OF THE NEED FOR A SMALL STATE-OPERATED HOSPITAL UPON THE ISLAND OF BLOCK ISLAND IN THE TOWN OF NEW SHOREHAM, RHODE ISLAND.

RESOLVED, That His Excellency, Governor John O. Pastore, be and he hereby is requested to appoint a special committee, consisting of five members of the medical profession, to make a survey of the need for a small state-operated hospital upon the Island of Block Island in the town of New Shoreham, Rhode Island. The members of said special committee shall serve without compensation and shall report their findings forthwith to the governor with recommendations, if any, for legislation to activate such recommendations, said legislation to be presented to the general assembly at its 1947 January session.

SENATE ACT 23

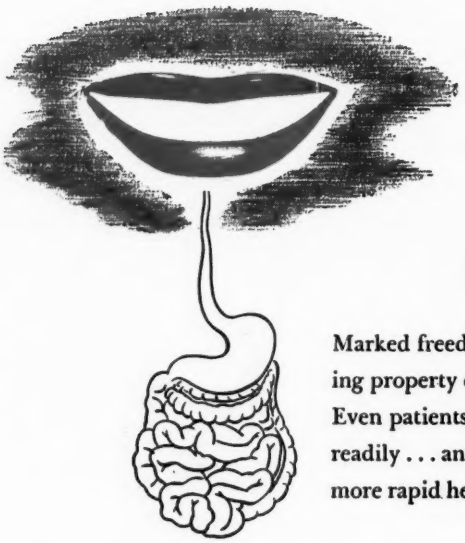
(Passed in concurrence by the R. I. General Assembly, April 17, 1946)

JOINT RESOLUTION

CREATING A SPECIAL COMMITTEE TO STUDY THE ADVISABILITY OF CHANGING THE NAME OF THE STATE SANATORIUM AT WALLUM LAKE, IN THE TOWN OF BURRILLVILLE, RHODE ISLAND TO "THE HARRY LEE BARNES SANATORIUM."

RESOLVED, That a special committee be and the same hereby is created, consisting of five members, two of whom shall be appointed by the presiding officer of the senate and three of whom shall be appointed by the speaker of the house of representatives, for the purpose of studying the advisability of changing the name of the state sanatorium at Wallum Lake, in the town of Burrillville, to "THE HARRY LEE BARNES SANATORIUM," out of respect to the memory of a pioneer in this state in the field of tuberculosis who gave so many years of his life to the upbuilding of the state's institution for consumptives.

The members of said committee shall serve without compensation and shall report to the general assembly on or before the fifteeth day of February, 1946.



Agreeable Iron...

Marked freedom from gastro-intestinal distress is an outstanding property of Fergon—Stearns' stabilized ferrous gluconate. Even patients intolerant to other forms of iron accept Fergon readily . . . and most patients show more efficient utilization . . . more rapid hemoglobin gain.

Fergon

STEARNS FERROUS GLUCONATE

For Hypochromic Anemias

THERAPEUTIC APPRAISAL: *Better Tolerated*—Fergon is only slightly ionized, therefore virtually non-irritating even when administered before meals. *Better Absorbed*—Fergon is soluble throughout the entire pH range of the gastro-intestinal tract. *Better Utilized*—as shown by comparative clinical studies.*

INDICATED in the treatment and prevention of hypochromic anemias, especially in patients intolerant to other forms of iron.

AVERAGE DOSE for adults is 3 to 6 tablets (5 gr.) or 4 to 8 teaspoonfuls of elixir daily; for children, 1 to 4 tablets (2½ gr.) or 1 to 4 teaspoonfuls of elixir daily.

SUPPLIED as 5% elixir, bottles of 6 and 16 fl. oz.; 2½ gr. tablets, bottles of 100; 5 gr. tablets, bottles of 100, 500 and 1000.

A trial supply will gladly be sent on request.

Frederick Stearns & Company
Division

DETROIT 31, MICHIGAN

NEW YORK · KANSAS CITY · SAN FRANCISCO · WINDSOR, ONTARIO · SYDNEY, AUSTRALIA · AUCKLAND, NEW ZEALAND

*Reznikoff, P., and Goebel, W. F.; J. Clin. Investigation 16:547, 1937

Trade-Mark *Fergon* Reg. U. S. Pat. Off.

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

The regular bi-monthly meeting of the Newport County Medical Society was held on March 26, 1946, at the Newport Hospital.

The meeting was opened at 8:55 P. M. with Dr. Alfred M. Tartaglino presiding.

The minutes of the January meeting were read and approved.

A letter from the Newport-Jamestown Bridge Commission requesting support of legislation pending in the Rhode Island Legislature was circulated.

A communication was received from Mr. Harry Feigelman inviting members of the society to be present at a meeting of the Newport Bar Association, at which Dr. McCarthy, the medical legal expert, was to be the principal speaker.

Dr. Frank W. Dimmitt was introduced and discussed the question of prepaid surgical service in Rhode Island under the sponsorship of the Rhode Island Medical Society. He stated that if such a plan were to be instituted, it seemed desirable to have it sold by the Blue Cross organization because of their low operating cost and their efficient going organization. He stated that, thus far, an enabling act had been passed by the legislature permitting this type of enterprise and that the Blue Cross had enlarged its board of directors to include a larger number of physicians. He stated that one of the things now being discussed was whether the plan would be on a service or on an indemnity basis, but stated that the Blue Cross was not interested in an indemnity plan. The New Jersey, New York City, Massachusetts and Michigan plans had been consulted in setting up a fee schedule. The plan in Rhode Island was being figured to include obstetrics and surgery in the home, office or hospital. One problem was a question of a fee differential for board members and members of the society in general. The question of the assistant's fee and the anesthetist's fee were in the process of being ironed out. As tentatively set up, the plan was to be restricted to single individuals, whose income was $2,000 a year, or under, and to married persons with an income of $2,500 a year or less. It was planned to indemnify other subscribers whose incomes are above the forementioned. In conclusion, he stated that while many kinks remain to be ironed out the individual members of the society would be asked to vote upon the plan before it would become effective.

Dr. Albert Jackvony then discussed a number of the questions which had been submitted to him by various interested members of the society in Providence, and he attempted to answer the various problems which they represented.

Dr. Samuel Adelson and Dr. James Callahan, delegates to the state society, who had had a part in the shaping of the society's plan, then gave their opinions of the plan in its present form.

Following a discussion by the members in general, the meeting adjourned at 10:35 P. M.

A collation followed.

Respectfully submitted,

H. W. BROWNELL, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held Monday evening, April 22, 1946, at the Pawtucket Golf Club. The transfer of Dr. Reginald H. Boucher from the Providence Medical Association to the Pawtucket Medical Association was received and approved.

Dr. James P. Healy, former Army Medical colonel of the 87th Infantry Division, gave an enlightening and interesting discourse on "Medical Service of a Division." Following Dr. Healy's lecture a collation was served.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, April 1, 1946.

There being no objection, the reading of the minutes of the previous meeting was omitted.

The Secretary reported the receipt of a communication from the Public Health Nurses Association calling attention to a series of meetings to be held at the Providence Lying-In Hospital to which members of the profession are invited.

continued on next page

The Secretary also announced that the Rhode Island Tuberculosis Association extended an invitation to all physicians to hear Dr. Richard H. Overholt, Chief of Thoracic Surgery at the State Sanitarium address the Annual Meeting of the Tuberculosis Association to be held at the Medical Library on Wednesday, April 10.

The Secretary reported for the Executive Committee as follows:

> At a recent meeting the Executive Committee of the Association approved the transfer of membership of Dr. Warren Ruhmann to the Kent County Medical Society, and of Dr. Reginald H. Boucher to the Pawtucket Medical Association.
>
> The Committee also recommended to the Association the election to associate membership of the following: Drs. Reginald H. Boucher, Francis D. Lamb of the Kent County Society, and Dr. Warren Ruhmann.

On a move from the floor the report was accepted and associate membership granted to the members named by the Executive Committee.

The President called on Dr. Edward S. Cameron, Chairman of the Air Pollution Committee, who presented the following report for his committee which consists of himself, Dr. Alex M. Burgess, Dr. Anthony Corvese, and Dr. B. Earl Clarke:

> "An act authorizing cities and towns in Rhode Island to control air pollution has been submitted to the General Assembly through the efforts of the Civic Committee on Air Pollution appointed by Mayor Dennis J. Roberts of Providence. The Committee on Air Pollution of the Providence Medical Association feels that the passage of this act would be very desirable and would pave the way for a modern up-to-date ordinance for Providence and for the other cities and towns in this State.
>
> "The Committee also reports that Mr. Philip Mancini, Public Service Engineer of the City of Providence, has an excellent proposal for an additional approach to the problem. He plans to furnish every fuel dealer with a printed card listing fuel burning instructions which the dealer will in turn deliver to each of his customers. Mr. Mancini plans to give public notice of this program in the daily press."

After Dr. Cameron's report Dr. Robert H. Whitmarsh placed before the membership the following recommendations:

> "1. That the Providence Medical Association give its endorsement to House Bill 870, an act authorizing cities and towns to control air pollution, which has been submitted to the Rhode Island General Assembly through the efforts of the Providence Civic Committee for Air Pollution Control,
>
> "2. That the Narragansett Electric Company be commended for its plans for smoke and dust control at its plant, and that it be commended for its leadership and foresightedness which should stimulate other industrial plants, large and small, to adopt similar measures,
>
> "3. That the Providence Public Service Engineer, Mr. Philip Mancini, be encouraged in his public educational campaign to inform fuel consumers, including especially the residential and apartment house groups, regarding proper instructions for fuel burning to lessen air pollution."

The motion was made, seconded and unanimously supported that these recommendations be adopted by the Association.

The President reported that an Obituary Committee of which Dr. Edward T. Streker is Chairman has been appointed to prepare the tribute of the Association to the late Dr. Howard Keefe.

The President announced that Dr. Robert R. Linton of Boston will address the Association at the meeting on May 6 on the subject, "Thrombo-Embolic Disease — Prevention and Treatment with Special Reference to Femoral Vein Interruption."

The President called upon Dr. Herman C. Pitts who briefly addressed the members and called attention to the Ball to be held at Rhodes for the benefit of the Field Army for the control of cancer. He urged that as many members as find it possible to do so purchase tickets to support this excellent movement.

The President called upon Dr. Guy W. Wells to preside over the panel discussion of experiences in World War II as related by the following physicians: Dr. Kenneth Burton, Dr. Alphonse R. Cardi, Dr. Samuel D. Clark, Dr. Nicholas A. Pournaras, and Dr. Wells.

Dr. Kenneth G. Burton was the first speaker and described his experiences as a member of a specialized surgical team, caring primarily for orthopedic casualties. During his period of service his team worked with field hospitals, general hospitals and evacuation hospitals in England, France and Germany. He described in interesting detail, the routine of work, living and moving from place to place. Some interesting examples of the confusion incident to mobile warfare were related. In one instance, his field hospital was nearer the front lines than the collecting station, and patients were evacuated from it, forward towards the front lines. There were several episodes of steady, unremitting work for as long as thirty-six hours at one stretch.

continued on page 379

DISTRICT SOCIETY MEETINGS

continued from page 376

Dr. Alphonse R. Cardi then spoke briefly on his experiences, and described the chain of evacuation from the front lines to a general hospital. He described conditions and terrain in Normandy, where the many hedgerows acted both as a protection and also, at times, a site from which they were ambushed. He described the handling of combat exhaustion cases in aid stations, by rest, sedation and food with the result that about 50 per cent were able to resume duty.

The next speaker was Dr. Samuel D. Clark, who briefly described the mission in the C.B.I. theater (China, Burma, India). He pointed out that the chief purpose was to get supplies to China, and that the major effort to this end was the construction of the Ledo road. He described in interesting detail his experiences with the 45th portable surgical hospital, which consisted of thirty-four enlisted men and four officers. They were assigned to the 22nd Chinese division, and had to work under what may reasonably be described as primitive conditions. Although the official capacity of their hospital was twenty-five beds, it at times expanded to a patient-load of 175 patients, because of difficulties in evacuation. Dr. Clark ended his talk by showing several excellent kodochrome slides, illustrating his experiences during this period of service.

The next speaker was Dr. Nicholas A. Pournaras, who served with the 4th battalion of the 4th Marine division. This was an artillery outfit, and his experiences were chiefly in island hopping in the Pacific. He described, in some detail, the conditions and his experiences on Saipan and Iwo Jima. He told us that on Iwo Jima, there were approximately 80,000 soldiers compressed onto an island of approximately 8 square miles, so that a shell seldom went off without damaging someone.

The program was concluded by Dr. Guy W. Wells, who described the experiences of his hospital with hepatitis, both with and without jaundice. This caused a serious loss of manpower, the patients were often sick for many weeks and there was a significant mortality attached to the disease. The clinical and laboratory features of the disease were discussed, and the paramount importance of bed rest in the treatment was emphasized.

Attendance 108. The meeting adjourned at 10:30 p. m. Collation was served.

Respectfully submitted,

FRANK B. CUTTS, M.D.

More Lasting Relief from Menopausal Distress

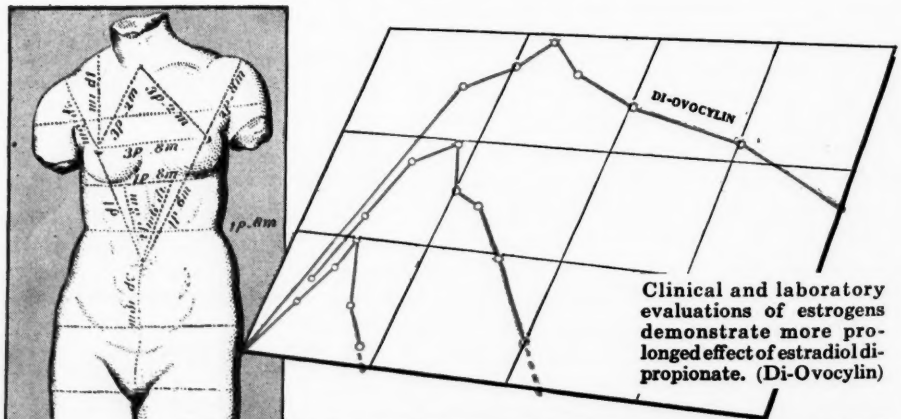
DI-OVOCYLIN

ESTERIFICATION prolongs the effect of this estrogenic hormone, thereby making fewer injections necessary. Di-Ovocylin, the dipropionic acid ester of alpha-estradiol, is therefore the therapy of choice for convenience and economy.

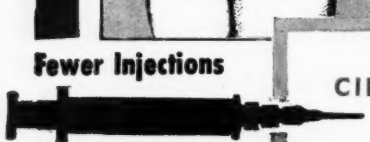
In management of the menopause, for example, Greene* points out that estrone injections may be required as often as two or three times per week, while a single injection of estradiol dipropionate, every fourteen to twenty-one days, will control symptoms in the majority of patients.

*Greene, R. R.; Int. Abst. Surg. 74:595, 1942

DI-OVOCYLIN—*Trade Mark Reg. U. S. Pat. Off.*



Clinical and laboratory evaluations of estrogens demonstrate more prolonged effect of estradiol dipropionate. (Di-Ovocylin)



Fewer Injections

CIBA PHARMACEUTICAL PRODUCTS, INC.
SUMMIT • NEW JERSEY
Steroid Hormones • Fine Pharmaceuticals

COUNCIL OF THE NEW ENGLAND STATE MEDICAL SOCIETIES

Report of the Executive Secretary at the First Annual Meeting, Held at Boston, Massachusetts, April 17, 1946

THE Council of the New England State Medical Societies was organized at a meeting of representatives of the various medical societies held at Providence, Rhode Island, on July 18, 1945. The Council, approved by the six New England state medical societies, met in Conference at Providence again on October 14, 1945, informally at New Haven, Connecticut, on December 13, 1945, when the representatives were the guests of the Council of the Connecticut State Medical Society, and at Boston, Massachusetts, on February 3, 1946.

In this, its first year, the Council of the New England State Medical Societies has proved that it has great possibilities as a conference group to coordinate and to publicize the viewpoint of organized medicine in this part of the country. From many states have come inquiries about the Council, all of which is an indication of the interest that has already been created by it beyond our borders.

Members of the Council have individually done much to stimulate interest in New England medicine and in the significance of organized grouping such as we have achieved within the past year. The Vermont State Medical Society honored the executive secretary, and Dr. Leslie K. Sycamore of New Hampshire, with places on the speaking program of its annual meeting at Burlington in October. Drs. J. R. Miller, J. H. Howard, and C. B. Barker, and also the executive secretary, were guests of the New Jersey State Medical Society at a conference on legislation and welfare held at Trenton in October at which much interest was evoked in the Council of the New England state medical societies. Dr. Miller, president of the Council, was its representative at the annual meeting of the New England Council, of which we have become a member, at Boston in November. On the occasion of the second Annual Conference of Presidents and other officers of State Medical Societies, held in Chicago at the time of the special meeting of the House of Delegates of the American Medical Association, Dr. Joseph Howard, president of the Connecticut State Medical Society, and a member of this Council, delivered an outstanding address on voluntary prepayment insurance for medical care. And at the meeting of the House of Delegates of the A.M.A., New England, already honored by having Dr. Roger I. Lee as president of the national association, received additional prestige and honor as Dr. James R. Miller of Connecticut received the largest vote of any candidate in contest for a post as a member of the Board of Trustees of the American Medical Association.

Highlighting the activities of the Council has undoubtedly been the successful Conference on Medical Service and Public Relations held in Boston on Sunday, February 3, 1946. Co-operating with the Council of the American Medical Association our Council presented an excellent program which proved most enlightening to the large number of New England doctors in attendance. Subsequently, printed reports of the addresses and the discussion were sent to the secretary of each of the New England state medical societies for their local distribution, copies in quantity were furnished to the Council on Public Relations of the AMA for national distribution to public relations officers of state medical societies, a copy was sent to each secretary of the state medical societies throughout the country, and a copy was sent to the head of staff of each of the major hospitals in New England.

The problems incident to medical care for veterans has been discussed by the Council. A report of the meeting held by the Connecticut State Medical Society in September was sent to each representative. Our October meeting was productive of excellent discussion that undoubtedly aided each representative to understand the problem better. The executive secretary sent out a list of state commanders of the American Legion and of the Veterans of Foreign Wars to each New England state secretary with the suggestion that such authorities be contacted by medical groups.

The Council has sent to members copies of reprints on national legislative matters, particularly the much discussed Wagner act. These reprints included ones by the AMA, and local ones from the Rhode Island, New Hampshire and Connecticut medical societies. A list of the New England Congressional representation, with their addresses, was also compiled.

The executive secretary has also sent to members during the year copies of the workmen compensa-

continued on next page

tion laws of each of the New England states; a report on the New Hampshire Physicians' Service; the study report of the Rhode Island Medical Society on its proposed surgical insurance plan, and more recently the first of what is hoped may be a regular News Bulletin to members.

In March the executive secretary, together with Dr. O'Hara of Boston, met with Dr. Carl Peterson, secretary of the Council on Industrial Health of the American Medical Association, in Boston. The meeting was called by Dr. Peterson who invited leaders in industrial health in this area to discuss the possibility of holding the 7th Annual Industrial Health Conference in New England in the Fall of 1946. The Conference would be cosponsored by the Council of the New England State Medical Societies, and it is significant to note that it would make the first time this national meeting has been held out of Chicago.

We may take justifiable pride in the fact that one of our members, Dr. Joseph Howard, President of the Connecticut State Medical Society, has been one of the national medical leaders selected to appear before the Congressional Committee holding hearings of the Wagner Act.

Your executive secretary concludes this first annual report with two recommendations to the Council.

One recommendation is that the Council give strong support to the plan to hold the 7th Annual Industrial Health Congress in Boston, seeing in this Conference an outstanding opportunity to publicize medicine in New England, the truly great industrial area of the country. The Conference will bring with its scope representatives of industry and labor, as well as our physicians, and therefore it places the Council of the New England State Medical Societies in a fine position to publicize favorably medicine in general, and industrial medicine in particular.

Secondly, your secretary recommends consideration of the advisability of an official bulletin of the Council that would have wide distribution. The thought here is that too often, as was indicated to us by several physicians at the time of our Public Relations Conference, we point our information to those who presumably are the best informed on the very matters upon which we seek to educate. Your secretary recommends, therefore, consideration of a plan whereby an address file may be compiled of the president and the secretary, or any other proper officers, of each district medical society in New England, as well as the chief of staff of every hospital in this area. Then at regular intervals, as seems advisable, and as the information seems important, a Bulletin of four pages or more

continued on page 390

CASE HISTORY

White female, age 63. Marked desquamation of skin on both hands (4 months duration), chills, temperature 101.4 F., leukocyte count of 10,400, eosinophiles 4%, lymphangitis of upper extremities, left supraclavicular lymphadenitis.

DIAGNOSIS: Eczematous dermatitis of unknown etiology (both hands), lymphangitis of upper extremities, and left supraclavicular lymphadenitis.

TREATMENT: 15,000 units Penicillin administered intramuscularly every 3 hours for 7½ days, plus massive wet dressings on upper extremities.

PENICILLIN

for SECONDARY INFECTIONS in ECZEMATOUS DERMATITIS

Secondary infections in eczematous dermatitis respond to treatment with penicillin when the condition is complicated with organisms susceptible to penicillin.

Bristol Penicillin, with its low toxicity and freedom from pyrogens, its absolute sterility and standard potency, provides dependable therapeutic action.

For additional current literature on the clinical uses of this potent antibiotic, refer to *your* issues of the BRISTOL PENICILLIN DIGEST.

Other products of Bristol Laboratories include high-type parenteral medications such as Epinephrine Hydrochloride, Liver Injection, Estrogenic Substance in Oil, and Phenobarbital Sodium.

BRISTOL
LABORATORIES
INCORPORATED

SYRACUSE 1, NEW YORK

N. E. MEDICAL COUNCIL

continued from page 388

be sent to each listed physician to give him pertinent information of New England medical problems in particular, and national problems in general. Such a Bulletin would in no manner overlap or invade the work now done by any or all of the state medical journals published in New England. It would serve, on the contrary, as a supplement and as a clearing house of factual information or informative data that might be of invaluable assistance to the physician who knows too little of the complex problems of organized medicine. The cost of this Bulletin would depend, of course, on the circulation, size, and frequency of issue.

Respectfully submitted,

JOHN E. FARRELL, *Executive Secretary*

April 17, 1946

STATE HOSPITAL FOR MENTAL DISEASES

concluded from page 368

however, and it is anticipated that the State Hospital will continue to be one of the leading institutions of its type in the United States.

The State Hospital has had nine Medical Superintendents. They are listed below with their tenure of office.

GEORGE F. KEENE, M.D.—May 21, 1899 to March 13, 1905
FRED B. JEWETT, M.D.—June 16, 1906 to April 5, 1907
ARTHUR HARRINGTON, M.D.—Aug. 1, 1907 to Oct. 1, 1926
RANSOME H. SARTWELL, M.D.—Oct. 1, 1926 to Jan. 11, 1929
ARTHUR P. NOYES, M.D.—March 1, 1929 to June 5, 1936
SETH F. H. HOWES, M.D.—June 5, 1936 to July 1, 1939
CHARLES P. FITZPATRICK, M.D.—Aug. 1, 1939 to June 1, 1943
JOHN R. ROSS, M.D.—Aug. 1, 1943 to March 31, 1944
JOHN F. REGAN, M.D.—April 1, 1944 to present time

NEWS ITEMS

A course in Psychiatric Nursing for affiliate student nurses has been introduced at the State Hospital for Mental Diseases. The period of training covers thirteen weeks of didactic and practical work in Psychiatric Nursing. The first class was admitted September 3, 1945. The present class of nineteen student nurses represents the Homeopathic Hospital, St. Joseph Hospital, the Memorial Hospital, and the Newport Hospital nurses' training schools.

A Picker Minograph has been received and will be installed in the near future. 70mm. photofluoroscopic films will be taken of all employees and patients, to expand further the tuberculosis control program at the State Hospital.

The Hospital Census has reached the highest point in history. The patient population now numbers 2,990.